NOW AND THEN

Center for Appalachian Studies and Services/Institute for Appalachian Affairs
East Tennessee State University

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From the National Archives

Hugh Pierce, miner, in hospital with broken leg caused by slate fall in mine. Harlan County, Ky., 1946. Photo by Russell Lee.

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Volume 6, Number 1
Spring 1989

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Now and Then Magazine

Now and Then has been published three times a year since 1984 by the Center for Appalachian Studies and Services (CASS), at East Tennessee State University. CASS is one of the State of Tennessee's Centers of Excellence, supporting artistic, scholarly and public service projects in the region. When you become a Friend of CASS ($7.50 per year, $10 for institutions and libraries) you will receive a subscription to *Now and Then* .

Submissions of poetry, fiction, articles, personal essays, graphics and photographs concerned with Appalachian life past and

CONTENTS

"Don't mow your yard, eat it."
—Tim Waggoner,
Author of ***The Poor Man's Medicine Bag***

COLUMNS..... 2-4

ARTICLES
Faith and Herbs
Folk Medicine in Appalachia
Anthony Cavender..... 6
Appalachian Ailments
A Quiz
Tom K. McKnight.....7
Health Advice
Then and Now.....8
from
•Gunn's Domestic Medicine
•The Poor Man's Medicine Bag
•Cherokee Plants
Rx: Stumpwater and Streptomycin
Urban Appalachian Health
Phillip Obermiller.....26
A Quiet Revival
Jane Harris Woodside.....28
Meeting the Challenge
A Highwire Act on the Qualla Boundary
Robert Gipe.....31

INTERVIEWS
Grady Stumbo:
An Ounce of Legislation
A Pound of School
Nancy Adams.....11

MUSIC
Denial
Steve Lyon.....25
Lunatic Asylum.....40

POETRY
The Last Mule Driver in the Fairmont Field
P.J. Laska.....5
Poem for James Collins
Bob Henry Baber.....12
12:02 A.M......19
Walter Haden
First Autopsy Observed by Six Freshmen Nursing Students
Hilda Downer.....22
Lines by a Moderator
Lorene T. Wagner.....27
Terminus
David K. Fenner.....30
Looking
Robert Cummings.....33

REVIEWS
Community Health Systems in the Rural American South by Carole E. Hill.....34
Gary Burkett
Appalachian Mental Health edited by Susan Emley Keefe.....35

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Summer, 1989
Sense of Place
An issue on regional writing

Fall, 1989
Art: Folk and Fine
New perspectives on Appalachian art

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CONTENTS

"Don't mow your yard, eat it."
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COLUMNS 2-4

ARTICLES
Faith and Herbs
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Anthony Cavender 6
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Meeting the Challenge
A Highwire Act on the Qualla Boundary
Robert Gipe 31

INTERVIEWS
Grady Stumbo:
An Ounce of Legislation
A Pound of School
Nancy Adams 11
Back to the Future with Midwives
Bonnie Fillers
Lucinda Flodin 13
Lucinda Flodin
Pat Arnow 16

ESSAYS
About My Healing
Tim Waggoner 5
Old Men
Abraham Verghese, M.D. 10
Night Comes to the Chromosomes
Pamela Zahorik 23

MUSIC
Denial
Steve Lyon 25
Lunatic Asylum 40

POETRY
The Last Mule Driver in the Fairmont Field
P.J. Laska 5
Poem for James Collins
Bob Henry Baber 12
12:02 A.M. 19
Walter Haden
First Autopsy Observed by Six Freshmen Nursing Students
Hilda Downer 22
Lines by a Moderator
Lorene T. Wagner 27
Terminus
David K. Fenner 30
Looking
Robert Cummings 33

REVIEWS
Community Health Systems in the Rural American South by Carole E. Hill 34
Gary Burkett
Appalachian Mental Health edited by Susan Emley Keefe 35
Steven L. Giles
Everything in its Path by Kai T. Erikson 36
Pamela Zahorik
Emerging Patterns in the Southern Highlands: A Reference Atlas Vol. 3, Health Care by Paul E. Lovingood and Robert E. Reiman (eds.) 38
Richard Couto
Gunn's Domestic Medicine by John C. Gunn 39
Richard Blaustein

Health care ideas and remedies suggested in this issue are printed for information only. No treatment should be attempted without consulting your health care practitioner.

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From the Director

This latest edition of *Now and Then* is devoted to a challenging and complex subject, health in Appalachia.

Ever mindful of the dangers of stereotyping and oversimplifying the history and culture of this region, we have done our best to suggest the spectrum of attitudes and practices relating to health and healing which can actually be encountered here, ranging from traditional herbalism, midwifery and faith healing to modern humanistic medicine and new age therapeutic alternatives.

Like other aspects of Appalachian history and culture, medicine and health care in the region have often been presented from the perspective of the antiquarian concerned with survivals of archaic customs or the social activist confronting generations of inherited poverty. Neither viewpoint gives us a realistic understanding of the actual complexity and dynamism of the region and its people (though the persistence of enclaves of folk tradition and pockets of poverty are undeniably part of the bigger picture).

Indeed, as we have discussed health issues and reviewed submissions for this issue, the staff of *Now and Then* has been struck by the pervasiveness of stereotyped ideas about health in Appalachia, even among highly educated people who seemingly should know better. Are there really more teenage pregnancies in Appalachia than elsewhere in America, more incest, more genetic defects, more family violence? One of our most disturbing findings is that while reliable information regarding these problems is hard to locate, nonetheless, there are Appalachian health care advocates and practitioners who are firmly convinced of the cultural and even genetic inferiority of mountain people.

Encouraging greater knowledge and understanding of Appalachian culture is only a partial solution to this problem. Health care professionals also need to be made aware of their own persistent erroneous beliefs, and how these unquestioned assumptions can prevent them from communicating effectively with their patients. Hopefully this issue of *Now and Then* will stimulate further discussion of these important questions.

The Center for Appalachian Studies and Services will soon be completing its fifth year of operation. We are all very proud of the progress it has made, and particularly of this magazine, which is now a substantial and progressive presence in the Appalachian Studies field.

If you appreciate what we are doing, let me encourage you to show your support by becoming a member of the center. Individual memberships are $7.50 and include three issues of *Now and Then.* Institutional and library memberships are $10 per year. Larger contributions and gifts will be greatly appreciated and will go to support the work of the CASS Fellowship Program which underwrites scholarly, artistic and public service projects serving the region.

For further information regarding the activities of CASS, please write or call me at the Center for Appalachian Studies and Services, Box 19,180A, East Tennessee State University, Johnson City, TN. 37614-0002. (615) 929-5348.

—Richard Blaustein

From the Editor

When I was working at a rural community mental health center in Appalachian Ohio a few years ago, one of the social workers asked me, "You know what my clients' biggest mental health problem is?" He answered his own question. "They're poor."

There wasn't much we as mental health workers could do about that. Jobs were scarce. We didn't have any more control than the clients did.

Control. That seemed to be an underlying problem everywhere we turned when putting together an issue of *Now and Then* on health in Appalachia. There are so many elements in Appalachian life that seem uncontrollable: floods, absentee ownership of resources, lack of jobs, domestic violence, alcoholism, memories of war, even hospital birth. These are national problems, of course—but some are made more severe in the parts of the region plagued by economic troubles.

On the positive side, we found that some people in Appalachia are trying to gain control over health problems in creative ways.

In Cherokee, N.C., one group is trying to reduce the high rate of alcohol abuse and violence there with Cherokee Challenge, a recreation program that teaches children about their own strengths and about their Cherokee heritage. This instills a sense of pride and self-esteem that should help prevent problems in the future.

We discovered two medical training programs that instill in students an appreciation of Appalachian culture and give experiences in real-world medicine. The goals are to integrate the culture of medicine and the culture of the people they serve and to keep graduates in the region after they finish school.

Midwives in East Tennessee are helping women take back control of the birth of their babies by maintaining the tradition of home birthing.

Some of the work in this issue outlines problems. Phillip Obermiller, for instance, shares his findings that Appalachians in urban areas are an invisible minority. Pamela Zahorik investigates some assumptions about inbreeding, lack of ambition and other stereotypes about the region.

Those writing in this issue live and work in this region. We hope that having these people define themselves rather than allowing others to define the region will help establish some of that control that is so necessary for the health and well-being of Appalachia.

—Pat Arnow

An anthology of work by and about Appalachian veterans is being compiled by Bert Allen, who was guest editor of the "Veterans" issue of *Now and Then* last year, and by Pat Arnow. We are interested in short stories, poetry, memoirs, diaries, photographs and drawings. Please send materials (with a self-addressed stamped envelope) to Veterans Editor, *Now and Then*, Box 19,180A ETSU, Johnson City, Tenn. 37614-0002.

From the Archives

To cure bladder and kidney ailments. One ounce of pipissewa root boiled in one pint of water. Take three times per day.

For constipation and indigestion: Dr. Thatcher's Liver and Blood Syrup. Also promotes a good appetite and provides energy.

Do yourself a favor. Invest in your good health with Johnson City Medical Center Hospital Community Health and Wellness Program.

Today Americans by and large think of medicine as a science. Yet, for most of the history of the United States health care has fallen within the province of folk medicine and/or patent (proprietary) medicine.

In the 19th century, even after the 1847 organization of the American Medical Association, most Americans mistrusted medical doctors and looked upon them as quacks. In Appalachia, as in other isolated regions, folk cures and proprietary medicines remained popular well into the 20th century, especially since the distribution of scientific medical health care services was limited until recent years.

The Archives of Appalachia and the University Archives hold materials on various medical approaches.

Folk cures, herbs and herb gathering are discussed by regional practitioners on audio tape in the Burton-Manning and Charles Gunter collections, and on videotape in the Broadside Television Collection. Publications also focus on folk medicine, including the 1971 work by Russell S. Walters, *Medicinal Plants of Appalachia*, and the popular 1830 Gunn's *Domestic Medicine* by John C. Gunn (see page 8 for excerpts from Gunn and page 39 for a review of a recent reprint).

Patent medicine was the rage in the United States roughly from the Civil War until the passage in 1906 of the Pure Food and Drug Act. This act legislated certain labelling requirements for patent medicines. Among these requirements was the stipulation that the presence and amount of certain dangerous drugs—alcohol, opiates and chloral hydrate, to name a few—had to be stated on the package. Other restrictions prohibited misinforming or misleading the consumer through faulty labelling practices. Use of patent medicines declined significantly after 1906, and in 1938 the Pure Food and Cosmetic Act outlawed proprietary medicines.

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INDIGESTION POWDER
A prescription relied upon to remove the causes of indigestion and dyspepsia. A restorative tonic for the stomach and digestive organs.
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THE WORLD —
KNOWN REMEDY

The Archives of Appalachia holds the records of the East Tennessee Medicine Company, a proprietary company founded in 1890 in Jonesborough, Tenn., by M.H.P. Panhorst, a medical doctor. Panhorst's most famous products were "P.I.P."—Panhorst's Indigestion Powder, and Panhorst's Liver Pills. Panhorst lost control of East Tennessee Medicine in the 1890s, at which time the company moved to Johnson City, where it remained in business until 1924.

More recent medical concerns are detailed in the records of the Council on Appalachian Women (1958-81), which include information on such health-related topics as rural maternal and infant health care, infant mortality, abortion, child development, and domestic violence. The Congress for Appalachian Development contains clippings from the 1960s on health care in Appalachia, and on mine safety and health. The materials from the Council of Nursing, Upper East Tennessee (1972-77), focus on attempts to expand health education in the area. The Tennessee Department of Public Health, Bumpass Cove Collection, concentrates on health issues relating to the dumping of toxic wastes in the Bumpass Cove Landfill, Washington County, Tenn.

The D.P. Culp Papers document the establishment of the medical school at East Tennessee State University during the presidential tenure of D.P. Culp (1968-1977).

All of the above-mentioned approaches to health care—folk medicine, patent medicine and scientific medicine—are crucial in analyzing the history and development of health care in Appalachia. Indeed, in recent years students of the history and sociology of medicine have come to realize that folk and proprietary medicine cannot be precluded from studies on health care in the U.S. Because the Archives of Appalachia promotes understanding of Appalachian culture from many perspectives, it seeks and welcomes materials on folk, patent, and scientific medicine. For more information on the archives and its collections please contact us at Box 22,450A, ETSU, or 615-929-4338.

—Marie Tedesco
Norma M. Thomas

Further information about the history of the Quillen-Dishner College of Medicine and about other regional medical history is available at the College of Medicine Archives, History of Medicine Museum and Library.

The History of Medicine library contains older medical texts, catalogs, biographies, autobiographies and 1,900 volume Carroll Long Collection.

The History of Medicine Museum features various equipment, furniture and instruments used by local doctors. Recreated is Dr. A.J. Willis's office that was in his home near the Taylor Bridge at Lamar, Tenn. Included are cabinets, medicine chests, examining table and office memorabilia. The museum offers an insight into the evolution of medical tools from the Civil War to the present.

The Medical Library and Museum is located at Building 4, Mountain Home Veterans Administration Medical Center, Johnson City. For more information call 615-929-6252.

—Charles Moore

From the Museum

Along the Washington Mall, between the Washington Monument and the Lincoln Memorial, stands a chevron-shaped wall constructed of polished granite, the Vietnam Veterans Memorial. Inscribed on "The Wall" are 58,132 names, the names of those who were killed or listed as missing in action in the Vietnam War. The memorial, constructed with funds donated by the American people, was dedicated on Veteran's Day, November 11, 1982.

At the dedication ceremonies was photographer Sal Lopes, there like the thousands of others to pay respects to those friends and loved ones whose names were inscribed in the reflecting surface of the granite. After this first visit Lopes came back many times, taking hundreds of photographs, images of the emotion and power present at the monument. These images were later to be collected into a traveling exhibition of 62 color photographs of the memorial and its visitors. Organized by the Chrysler Museum, Norfolk, Va., the exhibit opened at the Carroll Reece Museum last September.

The Vietnam War created a bitter division within the country. Families, friends and communities became divided. As conflict and controversy surrounded the war, so too the concept of building a monument to what many thought was a national disgrace. Not only was there opposition from those who had protested the war, but many veterans did not wish to see a memorial built, certainly not the proposed "black scar." The dedication of the memorial brought together many of those who had been at such a distance from each other and their country. A national healing began to take place.

The photographic images brought the emotional impact of the memorial to Johnson City. The exhibition became a step in confronting emotions—for individuals and for the community. The images also provided a perspective of the war to a generation too young to have memories of the conflict. For many of these visitors the war and its aftermath had been dictated by Hollywood images of Rambo and Chuck Norris.

Many visitors were visibly touched by the photographs and wrote their comments in our register before they left:

"I have never lived during a war—I have never had a close one to die in combat—But I have cried here anyway...we need to be reminded, those of us who have never been a part of it especially, so that this may not happen again."

"...Makes me want to know more about the war, but explains a lot of the things I have been confused about."

"I lost no close friends in the Vietnam War—I was one of the lucky ones. But I did feel a great loss when viewing these pictures; I lost so many brothers and sisters I never knew...I fear we have not yet learned our lesson."

Some of the comments indicate that the visitor was overwhelmed with feelings of gratitude for his/her own situation, having escaped personal loss.

"...I don't know the pain these people went through, but my father was in Vietnam, and I know my life wouldn't be the same without him."

"...I'm just thankful my husband's name isn't on the wall...he made it home."

"I feel very lucky not to have been touched (my life) by this, not directly anyway."

Not one of us on the Reece staff could have predicted that public reaction would be so positive, that the exhibition would serve to heal in the number of ways that it did. Never have we received so many expressions of thanks for any presentation. We add our thanks to the Tennessee Humanities Council and the Physicians for Social Responsibility whose funding made possible both the exhibition and the public programming. Thanks, too, to Dr. James Odom, Dorothy Douglas, the Vietnam Veterans of America, and to members of the Veteran's Administration staff for their support of this project.

—Helen Roseberry
Director
—Blair White
Curator

From the exhibition *The Wall*, photographs by Sal Lopes, 1982-1987. Organized by the Chrysler Museum, Norfolk, Va. The photos had an unexpectedly strong impact on East Tennesseans who saw the works at the Carroll Reece Museum last fall.

About My Healing

Tim Waggoner

The following is from a letter to ***Now and Then*** *from Knoxville healer Tim Waggoner. An excerpt from his book,* ***Poor Man's Medicine Bag,*** *appears on page 9.*

Tim Waggoner at the Smithsonian Festival of American Folklife in Washington, D.C., in 1986.

1. I do not charge.
2. I do not make teas and medicine for people. I tell them how.
3. People call and write to me from all over the country. I answer all mail, but I do ask people who write to enclose a self-addressed envelope.
4. People come to me that are desperate. I do not believe in operations except as a last resort because I have never seen anything that could not be healed without them. However, there are some things that can never be healed, such as rheumatism and gout. However, I can teach how to take away the pain and how to live with it. There would be very few operations if people would search out people like myself and sincerely listen to what they say. Some things I tell you may sound silly, but if you are smart enough to do them, you will find a cure.

I teach both old and new remedies. Remember, herbs are considered a food, and most have no ill side effects. Most of the drug medicines that I have used have more and more severe side effects than what you are trying to cure.

I base my theories on diet. You are what you eat. I tell folks, "Don't mow your yard, eat it." The diet definitely controls how long you will live. God told us in the Bible what we could eat and what we could not. He told Adam and Eve to eat the fruits of the trees. Tell me. What is better for you than fruit? He told us not to eat pork. We have found that this is the very kind of thing that is killing us. I believe in fruits, greens and beef. I also believe that for a long and healthy life the diet should include onions, garlic, olive oil, honey and greens, but especially wild greens because of their healing powers. My theory is that if you keep a healthy stomach, the rest of your body will be healthy.

I do believe that life is not in fat, and I also think that doctors made too big a deal out of it. I firmly believe that life lies in the blood. I believe that if you keep good clean healthy blood, you will live a long and healthy life. This can be done by drinking teas of red clover and burdock and by taking capsules of ginseng and echinacea.

I also do not believe in jogging. It does more harm than good, but especially to older men and women. As for women, it can even cause the womb to fall. I firmly believe that a good swift walk is the body's best all-around exercise. As for the blood, I am living proof. I weigh 290 pounds, and my blood pressure is like that of an 18-year-old. I can still do anything that I want to do. However, I work long, hard hours.

5. I teach classes of college and high school students about the art of doctoring with herbs and their benefits. I also teach survival and many other things.
6. Take care and take herbs, but be careful. You can overdose on herbs as well as on drugs. It is not serious most of the time like drugs are, but when you feel your head spin, you've had enough. Use them only to doctor with and to keep your body in shape. Plus enjoy an occasional cup of good ol' herb tea.

The Last Mule Driver in the Fairmont Field

At the Route 90 Inn
Dennis Sheets
is there early, half lit
cheeks drawn in
pulling on a wrinkled Camel
Between sips of a 10 a.m. beer
he tells the meanest
stepfather tale -
kicked out at sixteen
he went wrong. Reform school
then the State Penitentiary
at Moundsville - that time
he says for something
he didn't do - and laughs
as the pool playing crowd
comes in, his gold teeth
staccato among the white
All that time, he says
I never got kicked by no mule

—P.J. Laska

P.J. Laska's work has appeared recently in ***Laurel Review*** *and* ***Venue.*** *He lives in Morgantown, W.Va.*

Cartoonist Tony Feathers teaches art in elementary schools in Greeneville, Tenn.

Faith and Herbs

Folk Medicine in Appalachia

Anthony Cavender

Anyone who drinks a glass of warm milk to induce sleep, feeds a cold and starves a fever, puts tobacco juice on a bee sting, takes a shot of whiskey to break a cold, eats carrots to improve eyesight or wears a copper bracelet to ease the pain of arthritis, is practicing folk medicine.

Folk medicine was practically the only medical system in the Appalachian South up until the turn of the century. In more isolated areas where there were few physicians, folk medicine remained the only means of dealing with illness as late as the 1930s.

In the early 1800s "domestic medicine," a system of self-treatment that combined folk medicine—especially herbalism—and the newest medical knowledge spread through Appalachia through the publication of a variety of medical advisers. The most popular was Dr. John C. Gunn's *Domestic Medicine: or, Poor Man's Friend, in the Hours of Affliction, Pain, and Sickness,* first published in Knoxville in 1830. (A recent reprint is reviewed on page 39.)

It has been said almost every home in the region had at least two books, the Bible and Dr. Gunn's *Domestic Medicine*—which seems likely because Gunn's medical adviser was reprinted 213 times by 1885.

Naturalistic folk medicine—the use of plant, animal and mineral substances—was part of the Old World cultural heritage of the early settlers. Knowledge also came from Native Americans and from adaptive experimentation during frontier times. The leaves, stems, roots, seeds, fruits, flowers, buds and barks of plants were used for teas, tonics, powders, snuffs, poultices and smoke inhalation.

Mineral substances were also used in home remedies. The home practitioner put soot from a stove pipe on cuts, gave patients a piece of coal for heartburn, and rubbed coal oil or camphor turpentine on the chest for a cold.

While there would have to be questions about the efficacy of some herb and mineral remedies, many folk remedies have survived rigorous scientific study and have prospered as modern medicine. Digitalis, which is used in the treatment of heart disease, is derived from the foxglove plant. The drug was isolated by an English physician, William Withering, after he saw how well it worked as a folk remedy administered by a local herb doctor. From willow bark, a substance used for centuries in folk remedies in Europe and the New World, we now have aspirin. Today, more than 40 percent of all prescription drugs sold annually in the United States contain natural products, many of which have been used in folk medicine for well over 2,000 years.

Much of folk medicine relies less on physical remedies. The concept of transference underlie some of the supernatural cures in Appalachia. Transference—the belief that an illness can be transferred from the human body to another object—is illustrated in one of the treatments for the removal of warts. Warts are picked until they bleed, and then rubbed with kernels of corn. After the corn is eaten by, say, a chicken, the warts will disappear, having been transferred to the chicken.

Sympathetic magic—the concept that like affects like—is the basis of many folk cures, and is illustrated by a once-common cure for asthma. A stick of willow or sourwood was cut the length of the afflicted child and placed in the attic or cellar. As the child outgrew the length of the stick, he or she would also outgrow the asthma. Still another example would be the practice of putting an axe or knife under the bed of a woman in labor to "cut" labor pains.

Some magical beliefs relate to preventing illness. A person would turn his or her pockets inside-out after hearing an owl hoot. Fingernails, toenails and hair should not be trimmed on a Friday. Violating such taboos would result in illness or some other misfortune.

Other beliefs concern the prognosis of illness. If an ill person sees a shooting star, the patient will soon recover. Magical sayings are also employed for healing purposes. Saying "sty, sty, leave my eye" three times, preferably on Sunday, will get rid of that kind of infection.

Every individual possesses a personal store of medical knowledge. Some of it is based on tradition and some is highly idiosyncratic, acquired through individual experimentation. Healing specialists are those who either possess abundant folk medical knowledge or unique healing powers. There is a long tradition in Appalachia of "yarb" (herb) doctors and "Granny women" (midwives) who know a lot about home remedies.

There is also a tradition in the mountains of other kinds of healers. The seventh son who is a seventh son of a seventh son, or a man who has seven sons, is believed to have the ability to cure the "thrash" (sometimes called "thrush"), an inflammation of the mouth common among infants, by blowing into the mouth of the child.

Bloodstoppers are people with a gift for stopping bleeding. They place a hand on a wound and recite a Bible verse such as Chapter16, Verse 6 from the book of Ezekiel: "And when I passed by thee, and saw thee polluted in thine own blood, I said unto thee *when thou wast* in thy blood, Live; yea, I said unto thee, *when thou wast* in thy blood, Live."

The idiosyncratic element in folk medicine is illustrated by a practice of one rural East Tennessee community long ago. They said the thrash could be cured by having the infant take a ride on horseback with a local black man. In this community the elder male in the only black family the community was a local healing specialist.

The faith healer represents still another kind of folk healing specialist. While other types of folk healers mentioned above are perhaps not as common

as in the past, faith healing has remained widespread in the region—and elsewhere as well.

Advancements in scientific medicine, the emergence of other therapeutic systems and improvements in health care delivery have overshadowed all the forms of folk medicine in the region. However, folk medicine has endured and is being recreated every day. Folk medicine is of course the oldest form of medicine, and its endurance is attributable to the fact that it has proven successful in the treatment of illness—and because its application (as with any therapeutic system)—helps individuals cope with the anxiety associated with illness.

There has been a resurgence of naturalistic folk medicine throughout the country over the past three decades as evidenced by the popularity of health food stores and mail-order warehouses that sell medicinal plants, and the publishing of many books on herbal medicine.

In part this phenomenon reflects an awareness of the limitations of scientific medicine, but perhaps also the desire to return to a time that we perceive as simpler and more understandable. Whatever their motivation may be, those participating in the revival could learn a thing or two from the older people in the Southern Mountains who remember the time when folk medicine was the only medicine around.

Anthony Cavender, Ph.D., teaches in the Department of Sociology and Anthropology at East Tennessee State University. He has conducted research on folk medicine in the American South and in Zimbabwe.

Anthony Cavender is currently working with the Center for Appalachian Studies and Services on a research project exploring regional and local terms for illness, symptoms of illness and parts of the body. Those who are interested in participating as researchers or who would like to share their knowledge can write to CASS at ETSU Box 19180A, Johnson City, Tenn. 37614-0002 or call 615-929-5348.

Appalachian Ailments

A Quiz

Tom K. McKnight

Rarely have medical experts from outside the Appalachian region praised mountain cures and remedies for humans or animals. However, a few cures have proven their worth even in the chemist's laboratory. For example, the juice of dandelion stems, much akin to watercress and branch lettuce, has been used for generations to stop bleeding. Only recently have researchers discovered that dandelion stems are rich in vitamin K, which is a clotting agent. How granny-doctors and horse-doctors found this plant to be effective isn't known. In any case, it works.

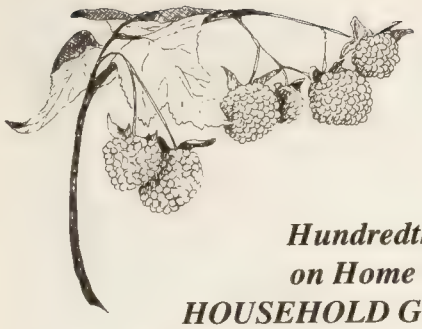
Along with using roots and herbs as ointments and tonics, Appalachians use names for ailments that can't always be found in medical books. This quiz can determine how deep your roots are here in Appalachia. In case you can't match up the names of the diseases with their colloquial names, the correct answers are located below. Good luck.

Symptoms	**Possible Answers**
1. an abscess on the sole of the foot	a. Saint Vitas Dance
2. inflammation of the tonsils and throat	b. a bealing
3. severe diarrhea ending in dysentery	c. beggar's itch
4. tuberculosis	d. the grippe
5. fall sores	e. a stone bruise
6. weakening of the legs and arms	f. a sty
7. a rising abscess or boil	g. the croup
8. jerky eyelids	h. the dry heaves
9. sudden inflammation in the lungs causing a cough that sounds like a barking dog	i. consumption
10. a skin inflammation similar to hives	j. milk leg
11. redness and soreness in the mouth	k. the bloody flux
12. flu symptoms	l. quinsy
13. infection on the eyelid	m. thrash mouth
14. scabies or irritated skin	n. colic
15. prolonged indigestion in babies	o. nettle rash
16. severe gagging after vomiting the stomach's entire contents	p. dew poisoning

ANSWERS: 1=E, 2=L, 3=K, 4=I, 5=P, 6=J, 7=B, 8=A, 9=G, 10=O, 11=M, 12=D, 13=F, 14=C, 15=N, 16=H.

SCORES: 1 to 5— You probably know someone from the mountains. 6 to 10— Your granny must have been an herb-doctor. 11 or more—Medical schools need you in their classes.

Tom K. McKnight, Ed.D. , teaches reading and English at Southwest Virginia Community College in Richlands, Va. His work has been published in ***Appalachian Heritage, American Annals of the Deaf,*** *and* ***Teacher,*** *among others.*



Health Advice Then and Now

From

Hundredth Edition, Gunn's New Family Physician: on Home Book of Health; forming a COMPLETE HOUSEHOLD GUIDE, giving many valuable suggestions for avoiding disease and prolonging life, with plain directions in cases of emergency, and pointing out in familiar language the causes, symptoms, treatment and cure of diseases incident to MEN, WOMEN AND CHILDREN, with the simplest and best remedies; presenting a MANUAL FOR NURSING THE SICK, and describing minutely the properties and uses of hundreds of well-known MEDICINAL PLANTS by John C. Gunn, M.D., printed in 1866.

from ***remarks:***
Avoid as much as you can dosing and drugging, and depend upon what I say to you, that thousands are killed by physic and the daily and constant use of remedies by which the stomach is worn out.

Then let me implore you to depend more on diet, exercise, traveling, change of climate, amusements, or on the presentation of new objects, by temporary absence from the cares of business; in other words, give the mind rest, for many persons are not aware of the serious ills inflicted by confining themselves to counting-houses, stores, and offices, with scarcely any exercise given the body during the day, and no rest of mind.

on ***intemperance:***
For the sake of the race, the drinker of ardent spirits should be separated from the domestic bed and board, and the wife, on establishing the fact of habitual intemperance, be entitled to a divorce...A drunken mother, a drunken father, a drunken husband, a drunken wife! fountains of seminal pollution, and a country's curse!

on ***the dread of death:***
...A second reason why men are led to regard dying as a very painful change is, because they often endure great pain without dying, and they infer that life can not be destroyed without still greater pain. But the pains of death are much less than most persons have been led to believe, and we doubt not that many persons who live to adult age, undergo tenfold more misery than they would, did they entertain correct views concerning the change..."

Dr. John C. Gunn, author of *Gunn's Domestic Medicine or Poor man's friend.*

on ***sleep:***
Solidification (that is, the conversion of blood into the solid parts of the body) goes on only during sleep...

on ***bathing:***
A man should certainly take a warm bath once a week; certainly a fortnight should not pass without one.

Colds and Coughs:
You will find Horse-radish an excellent remedy for hoarseness, Cough, Sore Throat, and all diseases of the lungs. Chewing a small piece, the size of the little finger, restores the voice, when so hoarse as scarcely to be able to articulate above a whisper.

Diseases of the Senses:
An excellent remedy for Ear-ache is: Take three or four roasted Garlics, and, while hot, mash; add a table-spoonful of Sweet Oil, and as much Honey and Laudanum; press out the juice and drop it into the ear, warm, occasionally. Onion-juice is also good, in place of the Garlic. If matter forms in the ear—if it gathers and breaks—inject warm Castile Soap-suds, and cleansing and healing washes, into the ear, by means of a small syringe, and apply poultices.

Vegetable materia medica

Pumpkin Seed—*(Cucubita Pepo)*—
Pumpkin Seeds are an excellent mucilaginous diuretic, very similar in their operation to the Watermelon Seed. To be used freely in infusion or tea in affections of the Urinary Organs, and Inflammations of the Bowels. Good in Retention of Urine, Inflammation of the Bladder, and to be used the same as Melon Seeds.

Raspberry—*(Rubus Strigosus)*—
The leaves are the part used as medicine, and those of the red species are considered the best. They are one of the most valuable astringents—to be used in decoction or strong tea, in Looseness of the Bowels, especially in the Summer Complaint. A strong tea of the Raspberry Leaves is also an excellent article, to be drank freely, in painful and profuse Menstruation, and to regulate the Labor Pains of women in Childbirth. A tea is also good to wash and cleanse old Sores, Ulcers, Scalds, and Excoriated or Raw and Irritable Surfaces.

*A review of a reprint of Gunn's original 1830 edition of **Domestic Medicine** appears on page 39.*

From

The Poor Man's Medicine Bag (Home Remedies and Helpful Hints) by Tim Waggoner 1984

Tim Waggoner of the Third Creek community of West Knoxville, Tenn., is a practitioner and student of folk medicine who has authored and published several books including ***The Poor Man's Medicine Bag.*** *He has demonstrated herbal medicine at the 1982 Knoxville World's Fair and at the Smithsonian Festival of American Folklife in 1986.*

First, let me say that I believe in doctors and the medical profession. Now, let me say that I want to go to heaven as bad as anyone else, but I will take every pill that I can get to help me stay here longer.

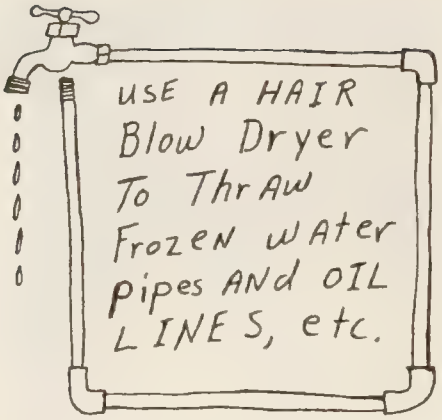
If my child is sick my love for it wants both divine and natural healing. This is why I ask for the prayers of the saints and then take my child to a doctor.

Wrinkle Cure

An old wives tale says that you can wipe your face with a diaper that a baby has wet in and you will have no wrinkles. I don't know whether it works or not because I have not found anyone brave enough to try it. Everyone prefers their wrinkles.

Sore Throat and Hoarseness

Chew horseradish root.



Headache Teas

Lady Slipper (root), Heliatrope (root), Thoughwort, Bonneset, Sage, Peppermint, Rosemary, Catnip, Chamomile, Celery, Aniseed, Lemon Balm and Lemon verbena.

Earache

Have a seventh son of a seventh son, or someone who has never seen their parents to blow into your ear and then use a good earache remedy.

Earache

Place a clove of garlic in the aching ear.

Reduce Inflammation

Use a poultice of cow manure.

Cosmetics

There must be a thousand and one ladies facial cosmetics available at drug stores, etc. However, I always did say even a painted old barn looked better.

Sexual Inability

Some may laugh, but this is a serious problem for many people. Sexual inability may be helped by not over-exercising, by eating carrots, watercress, asparagus, peanut butter, by chewing ginseng and by drinking lots of tea. it may even help so much that you might want to go help your wife make up the bed. If she has been eating and drinking the same, she will let you.

Poor Man's Medicine Bag , a 137 page soft cover manual, is available from Tim Waggoner at 3447 Reagan Avenue, Knoxville, Tenn. 37919, for $5.00 plus $1.00 shipping and handling.

From

Cherokee Plants: Their uses — a 400 year history by Paul B. Hamel and Mary U. Chiltoskey -- 1975

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u-ni-ye-gv *tsa-la-gi-yi*

Plants Cherokee

Medicine men possibly had a natural ability, but they refined their vocation by means of an apprenticeship. Much of their information was secretive and closely guarded, generally told only to selected apprentices. Most likely information on the use of plants was traded or shared with their peers. Anthropologists have determined that an individual medicine man may know 300 to 400 plants and their specific uses. Recently Amoneeta Sequoyah, a well known Cherokee medicine man, told L.C. Tankerskey, Jr., a reporter for the Pickens, South Carolina, *Sentinel*, he knew 642 medicinal plants. The accumulated knowledge of several medicine men in a village might reach 800 or more plants.

Horseradish

Diuretic; tonic; for gravel; increases appetite; aids digestion; for rheumatism; asthma; colds; obstructed menses; chew on roots for diseases of the tongue and mouth; gargle with tea for sore throat.

Garlic

Stimulant; carminative; diuretic; expectorant; a mild cathartic; useful for scurvy; dropsy; asthma; removes deafness; tincture prevents worms and colic in children.

Raspberry

Chew root for cough; leaves highly astringent; decoction for bowel complaint; wash for old and foul sores or ulcers; strong tea of red raspberry leaves for pains at childbirth; scratch rheumatism with thorny branch; ingredient in decoction for menstrual period; acts as emetic and purgative; tea drunk as tonic for boils; roots for toothache; fruit for food.

Cherokee Plants: Their Uses , a 72-page booklet, is available from Mary Chiltoskey, Star Route, Cherokee, N.C. 28719 for $1.50.

Old Men

Abraham Verghese, M.D.

I will never forget the face of the wizened old farmer as he stood in the rural clinic. He wore only a loincloth and carried a cane. He had been waiting patiently and now, as his turn came, he saluted me by bringing his palms together and bowing gently, his eyes lowered. It was not an obsequious gesture but a dignified salute. The clinic in India was miles from any sort of sophisticated care, my armamentarium consisted of my senses for diagnosis, and a scabicidal ointment and a plentiful supply of vitamin A and sulfa tablets for treatment. My compounder squatted in the corner of the room and dispensed the medications. The room was hot and constantly full of patients who watched my every move. The belief they had in the magic of medicines made it easy to please them, but they were not interested in a specific diagnosis.

God had blessed him, the old man said. He had had 10 children, and six had lived to maturity to help him plow the land. He owned two bullocks and in the last year there had been food for all his grandchildren. But for the past 12 years he had had more and more trouble breathing and increasing swelling in his feet. These were not the reasons he had come to me, however, as he had learned to live with these problems. For two months now he had been having fever, shaking chills, joint pains, and blood in his urine.

I found evidence of rheumatic valvular disease involving both aortic and mitral valves. He was in congestive heart failure, and his active precordium reminded one of a percussionist seeking to escape from within the wicker basket chest. More alarming were the embolic lesions on the skin, nails and mucous membranes. Without a doubt he had endocarditis, fatal if untreated.

I told him that he would have to go to the city for treatment, and would be in the hospital for at least three weeks. His look was one a father gives a child who tells of having just fought dragons. He told me that I was being modest and that he had no doubt my ointments and tablets would do wonders. The more I pleaded, the more amused he became. He told me that years ago when the revered leader of the country had died, he journeyed to the city to homage. The sights and sounds of the city had alarmed him, and he had resolved never to lay his head down more than a stone's throw from his farm. He left with the sulfa tablets in high doses, the vitamin A tablets and the scabies ointment to apply to his chest for good measure.

Years later I saw the same wizened face and benevolent smile at a Veterans Hospital. The man lived in the domiciliary on the grounds of the hospital. He loved to garden and constantly tended the shrubs or raked leaves, stopping periodically to puff on his pipe and survey the horizon. I liked to think he was admiring the Creator's handiwork. When he came into the hospital with pneumonia, he unquestioningly allowed us to perform a transtracheal needle aspiration. He seemed bemused by all our activity. My junior resident wanted to put in a central line and insert a Swan Ganz right heart catheter. I did not let all this be done, fearful of upsetting a fragile system that was in synchrony. I had heard doctors glowingly referred to as 'aggressive' and wondered whether 'agressiveness' was determined by the patient's disease or the doctor's mood. And were those of us who were not 'aggressive' in some way negligent? Had the existence of technology forced us to use it?

I later sat with the man on the hospital grounds. He told me that as a youth his closest companion was a 'coon' dog. He always felt that the old dog knew and understood much more than anyone gave it credit for. He brought this up, he said, because of his recent hospital experience; he sensed the resident felt pity for him and the other aged patients. He had overheard one of the residents refer to the patient in the next bed as an 'old gomer'! The funny thing was that when the man in the next bed spoke, (which was rare because of his stroke,) he had expressed pity for the poor, sleepless young residents running all over the hospital. My companion said that even though he could not get around well and had little money, he felt the quality of his daily existence was superior to that of any of the young doctors. He had no fear of meeting the Maker, and he hoped that old coon dog would be up there to meet him because he now understood a lot about the way it had spent its last few years.

The two old men were worlds apart, and each got something different from medicine; one tailored the medicine to his needs, the other followed the recommended medical course. The years had given them a quiet self-respect. Old age had brought infirmities, but it had also brought courage to deal with them. Both men viewed life from a stance slighty removed from the mainstream; they were patient, tolerant, and had a realistic idea of what their bodies could and could not do.

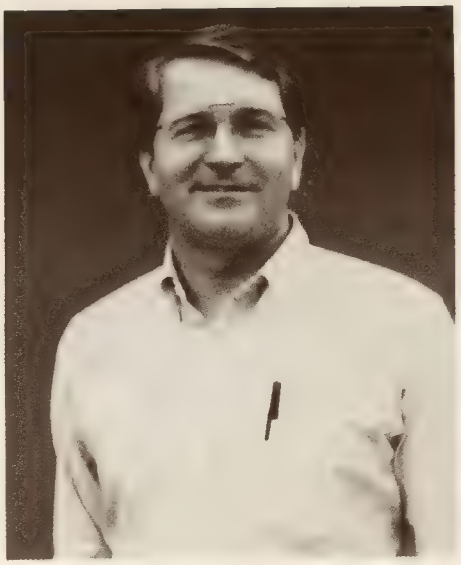
*Abraham Verghese has had a story accepted in the **North American Review** and is at work on a collection of short stories. He is an associate professor at the Quillen-Dishner College of Medicine at East Tennessee State University and Chief of Infectious Diseases at the Veterans Administration Medical Center in Johnson City, Tenn.*

Reprinted from Annals of Internal Medicine
Photo courtesy of the Johnson City Medical Center

Grady Stumbo

An Ounce of Legislation A Pound of School

by Nancy Adams



Dr. Grady Stumbo

As a boy growing up in an Eastern Kentucky coal camp, Grady Stumbo didn't consider going to medical school. No one in his family had ever graduated from college.

"Being a physician was something that was not possible for me," he says.

He attended Alice Lloyd College for two years, then vied for one of the school's scholarships to University of Kentucky. "They were going to give me a scholarship, but on the rankings I was kind of one shy. They had this one (scholarship) that nobody had taken for years and that was to go to medical school. I said, 'That's what I'm going to do.' And I went down there and did it."

As a student in the 1960s Stumbo witnessed the birth of government programs such as the Peace Corps and VISTA. He watched students protest against the Vietnam War. He began to think about what he believed in and what his mission would be.

About that time, Stumbo's friend, Benny Ray Bailey, started ALCOR, Appalachian Leaders in Community Outreach. Under ALCOR, college students from the region organized recreation programs for children.

Stumbo and Bailey also recognized that the region needed more doctors and nurses. They expanded ALCOR and recruited medical students to work in the region during the summers.

After Stumbo earned his medical degree, he knew his mission would be to return home and do what he could to help his community and the region. In 1972 he and Bailey started the East Kentucky Health Services, Inc., a primary care clinic in Hindman. He ran twice for the Democratic nomination for governor. He served as the state's human resources secretary.

Stumbo, 42, still sees serious health care problems in Appalachia.

Remote areas have trouble attracting physicians. High-fat, high-calorie diets contribute to above-average rates of heart disease and diabetes. Many pregnant women do not get adequate prenatal care. Teenagers have babies and drop out of school.

Yet, Stumbo says one of the most serious problems is that people can't pay for health care.

The signs are obvious. More people are not seeking health care because they cannot afford it. Patients owe his clinic an increasing amount of money. He has to give out medical samples because people can't pay for drugs. He doesn't turn anyone away even if the patient can't pay.

"They simply are having to choose between health care and paying rent, paying utilities, buying food. They can't opt for paying medical bills."

High health care costs are a national problem. Rising medical expenses, changes in federal regulations and cuts in entitlement programs have aggravated the situation.

But in the mining areas of central Appalachia, the dilemma is made worse by high unemployment rates and an economy dependent on coal.

Stumbo sees able-bodied 40- and 50-year-old men who have lost coal mining jobs and exhausted their unemployment benefits. "The unemployment rate has always been bad in Appalachia, but it's worse now. Take West Virginia, Kentucky, western Virginia. Those three areas are producing more coal today than in the history of the area, but they are employing fewer people."

Problems that block access to health care can be solved, Stumbo says. First, the government and private sector should strive to bring jobs to the region.

"Nothing is as eroding to the human spirit as to want to work and to look for work and to forever be without it. If we will create economic opportunities, a man or a woman or a family, once they get a job with good wages and good benefits, they'll fight for their family. They fight for opportunities for their kids. And they have some resources to get them"

One hindrance to creating jobs and diversifying the economy is lack of private capital. Often, Stumbo says, people from the area who get rich from coal mining invest their money elsewhere.

The region's universities and colleges could offer economic advice. "If they've got colleges of business that are so good, hey, why don't you guys tell us how to diversify the economy...They ought to be the bright shining star. They ought to show us the path."

Second, health professionals need to be encouraged to settle in rural, underserved areas. Although the region is better off now than it was 15 years ago, there is still a need for a range of health workers, from doctors to physical therapists to nutritionists.

More scholarships should be made available to young people from the area who want to go to medical school and return to serve in their home communities. But, even if there are more scholarships, Appalachian students still have trouble getting into medical school, Stumbo says.

Sometimes their grades don't meet entrance requirements or their Medical College Admission Test scores are not high enough. "Our grades aren't good enough because our schools are lousy. Our schools are lousy because government hasn't done what it is supposed to do. We let the coal companies own all the coal and don't make them pay an unmined minerals tax. You run the

schools on property tax, but you don't put the tax on the property.

Stumbo can empathize with students from the region. His medical school admission test scores were not high. "But by the grace of the good Lord, I got in. I was successful."

Admission requirements should not be lowered for Appalachian students Stumbo says. But allowances should be made for bright, young people who are motivated to do well in medical school. "I think you can look at young people and their activities and their motivation. What do they want to do? What about that sense of idealism and caring, that feeling that, 'I'm here for a mission.'?

"I'm saying that the most likely person to come back into rural West Virginia, Kentucky, rural East Tennessee are those bright, young motivated people who want to come home and change the way things are. They just need an opportunity."

Not every community will be able to attract doctors, Stumbo says. "The more specialized they are, the more difficult it gets."

To solve that problem, the state should start designating regional health care centers that staff specialists. "I don't need a cardiologist in this facility. We need good family doctors. But I need access to a cardiologist, access to orthopedists."

Third, the country needs to decide what kind of basic health care people are entitled to. "The problem of access to health care is so big that there is no way the private sector can solve the problem. It has got to be a government problem, in part."

Catastrophic health insurance is essential, Stumbo says. He also thinks all employers should offer health benefits. To explain his position, Stumbo used the example of a part-time worker at a fast-food restaurant.

"One of the ways they sell things as cheap as they do is that they don't provide any benefits. If you work there and get sick, the taxpayer has got to pick it up. So the taxpayer is subsidizing a lot of these minimum wage jobs. We've got to say that workers have a right to some kind of insurance."

States in the region also need to address the high teenage pregnancy rate. "We need to attack that problem head on because that really fosters the high school dropout, the poverty. It is a cycle. Nothing is as oppressing as the failure to educate the young generation and allowing them to drop out. The attitude that we have in the communities, "Yeah, you can drop out." I think the single best thing we can do for the young generation is to insist that they get a good education. We have to provide it, to make it available, and they have to get it."

Stumbo predicts the quality of health care for people in central Appalachia will improve, but he remains concerned about care for pregnant women and young children. Nutrition, Head Start and day care programs should be expanded, he says.

He is also worried about care for elderly people. "The aging population has been left alone, many times, because their kids had to leave to go get a job. Their kids have now raised a family in Detroit (for instance). These elderly people are growing old alone. That's not a characteristic you're used to seeing in Appalachia because we had the broad, extended family. I think unless somebody really initiates some in-home services program in a more comprehensive way, we are going to have a real crisis in caring for elderly people."

As for his future, Stumbo sees himself as a rural family doctor who will continue to speak out on issues that affect his community and the region. "We have to have professionals in the future who are quite willing to accept that some of their responsibility is outside of their examining room walls."

Nancy Adams, a freelance journalist, lives in southwestern West Virginia.

Poem for James Collins

Now youse may not believe it, but its the truth
I throwed lumps as big as I could lift
to get my Daddy his quota.
Why coal was so much a part of my life
I thought God made it before he made night,
but tell *that* to the Labor Board
and see what'll getcha—
a nock on the noggin' with that headache stick
the sheriff's got ahangin' on his hip

this ain't suppose to be a slavin' place
but we got widders out here
their husbands die
and they tell her autopsy autopsy
cut him open
see if he got blacklung
hold them lungs up to the light
listen to hear
iffin there's any air left to be wrung out
but this ain't supposed to be a slavin' place
tell 'em that
see if they stop pattin' their hair
and clicken' their pens,
scream, it in their ears
THIS AIN'T SUPPOSE TO BE A SLAVIN' PLACE
they'll say youse outa order Mister—
treat youse like youse a pop machine or somethin'

youse outa order Mister, outa order

Well if this be order
give me a wheelbarruh of chaos
and a pop bottle full of shook up rattlesnakes

—Bob Henry Baber

*Bob Henry Baber co-edits **Pine Mountain Sand and Gravel** and works for Appalshop, the media production center in Whitesburg, Ky.*

Childbirth

Back to the Future

It's still possible to have a baby at home with a midwife in attendance in Tennessee. The following are conversations with two of the women who practice in East Tennessee.

Bonnie Fillers

by Lucinda Flodin

Midwife Bonnie Fillers

Mrs. Bonnie Fillers has worked as a midwife around Johnson City, Tenn., for 42 of her 77 years. She grew up on Simerly Creek Road, about two miles from Limestone Cove in Carter County and moved to Johnson City when she was 15 years old.

Q: How did you become a midwife?

A: I went with my mother, and I knew right away I really wanted to do that kind of work. I started after I was married——my mother wouldn't let me go until I was married. The first baby I saw get born was my own. Then I started to go with her.

Q: Was your mother always a midwife?

A: No, she got in a place where she had to do that one time, and after that they started to call on her when people had babies.

Q: How long did you work with your mother?

A: I went on with her a long time. Really, I didn't start to deliver much until she had to quit. She lived to be 88, and she never got past going around. She just went 'til she died.

Q: Were you the only one of her daughters to become a midwife?

A: I was.

Q: What was your mother's name?

A: Lilly. Lilly McKinney.

Q: Tell me that story about Emmaline Hyder. (Mrs. Hyder was a midwife in the Simerly Creek area when Mrs. Fillers was a girl.)

A: I wonder now how children feels about me, you know. I didn't like Mrs. Hyder. I told my mother one day, 'I hate that old woman. Every time she comes here she leaves a squalling baby for me to tend to. I don't like her. I'd like to whup her,' and I got a whipping for that, honey. I knew when she come there was going to be a baby. I wonder if they feel like that about me. Some children come out and ask me to bring babies. Like my own daughter when she was small, she said, 'Mama, can't you bring me a baby?' I said, 'No, honey, I can't.' She said, 'Well, you take them to everyone else, why can't I have one?' I didn't know what to say to that.

Q: What do you carry with you to births?

A: My scissors, my little syringe, my cords, my eyedrops and my birth certificates.

Q: Did you ever have a license or have to be certified?

A: No. Back when I started, if you had as many as three babies, you could be a midwife.

Q: Do you remember the first birth you attended alone?

A: They came after me before I started delivering babies. She sent her daughter after me. she said, 'Mama wants you to come and help her get ready to go to the hospital.' I got there and she was lying there. I said, 'You better let me help you get ready if you're going to the hospital.' She busted out laughing and said, 'I'm not going to the hospital. You're going to deliver.' I said, 'Okay, if everything's all right.' And I went ahead and delivered the baby. Been helping ever since.

Q: Do a lot of people just show up at your house, or do you meet them first?

A: There's some that just shows up at the house, but I'd rather they come before it's time. I like to meet the patient and talk to them and everything.

Q: It would scare me to have someone just show up at my house in the night. You must be very brave.

A: I am.

Q: How did your family feel about your work?

A: They were glad. My husband didn't mind. A man asked him once, 'Don't you care for her going out to do work like that?' He said, 'No,' and the other said, 'Boy, I would. If I had a wife as pretty as her, I wouldn't let her go at all.' He said, 'I trust her.'

Q: What was the largest family you delivered babies into?

A: Well, there was 13 children. I only delivered the 13th. We weren't acquainted, but I'd become acquainted with her sister at a place I was delivering a baby, and she told her sister. And they came to get me. She was 42 at the time. She said if she'd known how much better it was

to have her baby at home with a midwife, she'd a had every one there. She got along better than with any of them.

Q: When you started, men weren't at the births. Do you think that's a good change?

A: Yes. I think it's really better for the husbands to be there. It can give her confidence. It makes better fathers. One father——it was getting pretty close to the birth——he said, 'Have you ever had a man faint?' I said, 'No. If I had, I'd beat him.' His eyes got big. I said, 'You get over there on the side of the bed and let her rest against your chest and let her hold your hand. Now, don't you hold hers. Let her hold yours.' It weren't five minutes before that baby came. He didn't faint. He said, 'Well, I didn't think it would be like that.' Honey, I've been at some tough ones.

Q: Tell me about some of the tough ones.

A: Well, I've been where they didn't even have a string to tie the cord. I had to tear a pillowcase. That's back before I started taking my own cords. They didn't have no water to wash the baby with. They had only just enough water so I could wash my hands one time—and I was worried to death, but I made it. Not a diaper. For the longest time after that, I carried cloths with me. I got to washing white cloths and putting them in my oven to sterilize them.

And something else—when I'm contacted to deliver a baby and the time is close, I can feel it. I get all my stuff together and I get ready to leave at a moment's notice. I watch the changes of the moon, too. You can notice that a birth is generally close to the changes of the moon. There's just a feeling that comes over me, when I'm gonna get called.

Q: Did you ever have trouble with a baby?

A: One time I thought I was gonna lose one—but I didn't—cause the mother was real sick. It lacked a little of being time and she was real sick—an abscess tooth and throat and she was in bad labor when I got there, and I had to go about a mile down a steep hill. There was snow to my knees. When I got there, I knew it was early, but I knew they couldn't get her out of there. I said, 'I'm gonna do my best 'cause she can't make the trip out. If an ambulance could get here I wouldn't try. This baby may be born with a cold.' I went ahead and delivered it. I worked on that baby three hours. I did about everything, rubbed it with oil, syringed out its nose and everything. I said, 'I've done all I can.' and told them to call me in the morning. They didn't have a phone. Some of their neighbors did, so they called me the next morning and told me the baby was doing all right. They didn't have any money to pay me, but it's all right. I just went on anyways. It went on; they came after me again. He said, 'I know I didn't pay you—it hasn't been so I could. I have in a crop of tobacco, so I'll pay you for both.' I said, 'That's all right,' and I went on. I delivered one. After I got it dressed I could pick it up on my hand, it was so tiny, about three pounds. I didn't have a bit of trouble with it. Neither did they.

I told you I delivered one dead. It was an easy birth. As quick as I seed its face I could tell by its color. The baby'd been dead awhile. It was so limp I couldn't lift it. I had to fill out a death certificate. The rescue squad came and the coroner. There was nothing that could be done, but it just broke my heart.

Q: What do you do at a birth? When you get to someone's house, are there things you always do, or do you wait to see what's happening?

A: I wait and see how the pains work. I give them awhile, then I cleanse my hands and arms and make an examination to see if they're dilating or if it's false labor, and if they are dilating, well, then every so often I'll check them.

Q: How do you catch a baby?

A: I use a lot of oil. I rub them all over maybe two or three times before the birth. As the head comes down, I put oil on it and as it slips out I put my hands and help ease it out.

Q: It's so exciting when the baby is born. Is it still as exciting after so many years?

A: Oh, yes—it's just as exciting. There's no difference.

Q: What do you think of having the other children in the family at the birth?

A: It's all right if they want them. The first time I felt kind of bad. I got to thinking that maybe it would cause them to never want to be a parent. If they saw their mother suffer like that, a girl might never want to be a mother or a boy, he might never want to see his wife hurt like that. A 9-year-old was at a birth once, and he stood right beside me and she had a bad labor—she didn't tear or anything—it was just a long wait and he was standing right beside me and he'd say, 'Come on out, baby, come on,' and I turned around to him and said, 'Honey, don't be scared, she's all right, she's just fine.' He was pale and I thought he was scared.

Q: Tell me again about the woman you went to the hospital with.

A: She was having pains so fast, and she was so young. They told her she was gonna have to do something about it and they told her she could have a tubal. She said, 'Will I have to go to the hospital?' They said yes and she said she wouldn't go. She said, 'I want my midwife. She brought my first one and delivered three others for me. I want her there.' The nurse talked and talked to her, and the doctor talked and talked to her and finally they asked if she'd go if the midwife could go too. So they let me go. See, I'd delivered four for her, I knew how she was, and it was getting right close. The only thing I could do was hold her hand. The nurse cut her.

Q: Had she ever been cut before?

A: No—she'd never had a tear. And she said, 'Oh, Lord, Bonnie didn't do me that way. I'm hurting so bad. I never hurt this bad when Bonnie took care of me.' The nurse said it would be over in a little while. I said, 'No. With the next pain the baby will be here.' She said, 'Do you think so?' I said, 'I know it.' The next pain, here comes the baby. The doctor was in another room, the baby was born to the waist before he got there. I

couldn't touch that baby. I wanted to put my hands under its head—it would have helped her, too. I couldn't hardly keep from touching it to have saved my life. The nurse said, 'I didn't think it would come so quick.' I said, 'I knew it would.' When the doctor came in, the nurse said, 'This is the lady who delivered her other babies.' He said, 'She almost delivered this one, too.' I would have delivered it, too, if they'd let me. She loves me to death. Every time she sees me she just hugs my neck.

Q: You must feel like you have a very large family.

A: I do. Babies, men and women, too.

Q: What's the hardest thing about being a midwife?

A: Well, I think if a body'd have an accident and lose a baby, you know, they'd be blamed awful bad, even if it wasn't your fault. It's because we're women.

Q: Do you think it's *just* because we're women?

A: In a way.

Q: That doesn't seem fair, does it?

A: No, it doesn't.

Do you remember that one they named Amber Rain? It rained that whole day. It was mud from here to here. I didn't think we'd ever get out of there. We'd worked all day and the baby wasn't moving, so she got up and walked and walked and walked. I told her we'd help her get ready, so we did and she got as far as the door and said 'I can't go no further,' and they grabbed a blanket and pillow, and I got down on the floor to deliver that baby. I had to get help to get back up!

Q: Tell me about helping your grandchild give birth.

A: My granddaughter was 15 and she was having a baby and her husband and mother thought she was going to the hospital and she was in labor, and she refused to go. She said, 'I trust my grandma more than I do anybody. I ain't a-going,' and she started to cry. My daughter said, 'Mama, what do you think of this?' I said, 'Well, if everything's all right, she can stay if she wants to. The doctors can't do no more.' She said, 'I don't want to (go),' so at 6:00 o'clock the baby was born and she got along real good.

Q: That must be very special.

A: It was. Later she told me she was gonna give her back to me. She told me that she'd always heard that whoever handled a baby first, they'd be natured like them. 'She's just as ill as you are—I'm gonna give her back.' I said, 'No, I don't take babies back!'

Q: It must be wonderful to see your babies grown.

A: It is. I've delivered girls and then their girls.

Q: Does it get harder to get up in the night?

A: I don't pay any attention to it. If you're used to anything it don't bother you. You get tired but you don't notice it 'til everything's over. I delivered this one baby for this girl. They'd been married 12 years, and this was their first. She weren't moving along much and she was giving out, and I was, too. Her daddy was a preacher. They called, and he came over, and he prayed for me and her both. He prayed for the Lord to give me strength. He prayed for her and you know it was just a little while 'til that baby come and they were tickled to death with that baby. God looks after little babies.

Q: Tell me about the twins you delivered.

A: I went to this place, and I had delivered three babies for her. She hadn't seen a doctor, and I asked her if she didn't think she was larger than she had been before. She thought she was. She went into hard labor sooner than she'd been, and she lingered for a long time. One was born, and it weighed eight pounds, four ounces and I put my hand on her stomach and said, 'There's another one.' She started crying and I said, 'Don't worry. I'll take care of you.' In 15 minutes a girl was born which weighed six pounds, two ounces. I was surprised, and she was surprised, and you know it was really easier than the single births. Quicker and easier. Her house was full of people wondering who delivered them. It was Good Friday.

Q: Do you ever get scared?

A: No, I never get scared. You can't if you're gonna be a midwife. You have to keep your mind on the woman and the baby and what's going on. I don't care how many people's around. I just pay attention to the woman and the baby.

Once, when I hadn't been delivering long, I went to this woman I never met before. She wrote a letter and wondered if I'd come. This lady who lived close to me, she knew her. She said, 'I'll go with you when you go.' So I went. There was a real old lady sitting there towards the side of her when I got there. There were several other women there. Directly I noticed some whispering around. One of them said to the woman I was with—they knew her—'When's the midwife coming?' She said, 'This is her.' 'Why, that couldn't be her. She looks too young to be a midwife.' She said, 'Well, she is. She's a good one. She delivered two for me already. She's the best.' Well, the worse she got, the more they's a-leavin'. That old woman was still a-sittin' there. I said, 'I'm gonna ask one of you to help me.' Lord! they commenced to goin' at that. And that one that went with me said, 'I'll help you.' So I delivered the baby, and after awhile that old woman said, 'Well, you done a good job. I was a midwife.' I said, 'You was?' She said, 'Yes. I'd have delivered that baby if she was married.' That didn't have anything to do with anything. I went whether they was married or not. Every woman hurts. I've had people say to me, 'I wouldn't go over there. She ain't married.' I say, 'She hurts just like any woman.' If I could help her, I will. I was never prejudiced about nothing.

Q: Do you think you'll ever retire?

A: If I was ever to get so's I didn't trust myself.

Q: What makes a good midwife?

A: Well, they've got to have a lot of courage and they've got to have a lot of good nerve and they've got to trust themselves.

Lucinda Flodin

by Pat Arnow

Bonnie Fillers is not one of a vanishing breed. Her interviewer, Lucinda Flodin, of Carter County, Tenn., and Flodin's partner Martha Perkins of Unicoi County, represent a new generation of midwives who are carrying on the same traditions of home birthing—though there are some new twists. Flodin was raised in a suburb of Chicago and received bachelor's and master's degrees in acting and directing from Illinois State University in Normal. Over her 15 years in East Tennessee, she has evolved into an herbalist, midwife and storyteller. She lives on a small farm with sons Forest, seven, and Cody, six. The family grows most of its own food, and the children are schooled at home.

Midwife Lucinda Flodin

Q: How did you meet Bonnie Fillers?

A: I was at a birth with her. A friend was having a baby, and my job was to go and get the midwife.

Q: Had you ever thought about being a midwife before?

A: No.

Q: That's what inspired you?

A: Oh Yeah. It was amazing. So I kept on doing it. It was such a miracle. I still sit at births sometimes and don't believe it could really happen.

Q: What happens at a home birth?

A: Usually we come in and talk a bit—unless the woman's waited to call until she's about to have a baby, which happened once—I was getting Forest out of his car seat, and Martha said, 'You'd better hurry.' I ran in the door, put out my hands and caught a baby. Literally.

But it doesn't usually happen like that. Usually we sit down, and we talk. We'll ask how the contractions feel, how long they're lasting, how dilated she thinks she is. Is she happy or is she feeling kind of frantic, scattered? What does she need? We'll check and see the dilation, the blood pressure, listen to the baby's heart, make sure the baby's still in the same position it was the last time. Assess whether or not we should all stay awake and wait for the baby or if we should all try to sleep. It can be a long time. We might make tea, turn the lights down low. It all depends. Labor is different for everybody.

Q: What do you do for pain?

A: We use relaxation. Breathing. We don't usually use Lamaze, which is different types of breathing for different types of contractions. We encourage them to breathe deep and focus on the breathing, visualize their body, their cervix opening up. The beginning of labor to full dilation is mostly a process of relaxing and letting go to what your body's going to do whether you let go to it or not. We help the woman remain comfortable. That can mean making cups of tea, rubbing her feet, rubbing her shoulders, rubbing her back. It can mean just sitting talking to her, cracking jokes. I think it's important to keep a good sense of humor while you're in labor. People who are laughing are really relaxed. It's a crazy situation. You're having a baby. It's intense, you gotta laugh. Because sometimes it's so out of control. A lot of coming to terms with labor is learning the strength of yielding. Letting go. Letting your body do what it really knows how to do.

Q: What do you do after the baby comes out?

A: I put it up on the mama's belly so that the first touch of that baby's life is more from its mother and its father than it is from me. If we need to suction we'll suction with the infant on the mom.

Q: They're breathing?

A: Yeah, usually they start right out. We've never had to resuscitate a baby. Most of the time they just breathe, turn pink and look great. Seeing someone who is just brand new is...such a blessing, it's hard to describe. A whole perfect person.

Q: When you see that in the hospital, do you get the same feeling?

A: Not really, because often the baby doesn't go right to the mother, it goes to a pediatrician who works on the baby in a warming tray. They give it shots, they put stuff in its eyes. They make sure it's breathing all right. And they suction. At two of the hospital births I witnessed, they held the baby up, and said, 'Here's your baby!' Some hospitals will let the baby stay with the parents for awhile before it's taken to the nursery. Then it's taken away and the next time the parents see the baby it's clean and neat and sterile (laughs).

And if there's a problem it's even worse. Usually if the babies come out and they're flaccid, if their mothers talk to them or touch them they will be all right. Literally. I worry when something's wrong with the baby in the hospital. The first thing they do is take it far away. It seems to me the thing they're forgetting is the most powerful tool they have, which is the person who is most connected and most loves the baby. To put them in separate rooms because they have a problem doesn't make any sense.

Q: Are you saying they're ignoring the spiritual?

A: Or not even considering that that might be important, that it would exist, that it would be a tool. The difference between an obstetrician and a midwife is vast. Obstetricians learn in school all the things that can go wrong and how to fix them. Midwives learn the ways in which birth almost always goes right. When

obstetricians learn to do births they don't even sit with a woman who's in labor. They're called when the woman is completely dilated to come in and catch the baby. They never see the whole process of labor, so they don't know very much about it. So far in medical eduction, no one has thought that was important. But I don't know how you can be the expert on birth unless you see firsthand the whole process. Sitting through a woman's labor teaches so much about her labor. Instead you have someone coming in and judging what her labor is on a machine or by numbers. She's this many centimeters dilated. The fetal heart tones are... Those are important things, but they're not the whole picture. They're missing so much. I was in a hospital once with a woman, and when they took her into delivery, before calling the obstetrician, the OB nurse said, 'I'd better check you again because if you're not completely dilated, the doctor is going to have my head.' The doctor can't be there for one centimeter of dilation? I know they're busy, but that's too busy.

Q: What tools do you take with you when you get called?

A: I take a fetalscope, stethoscope, blood pressure cuff, scissors, cord clamp, hemostats, suction, oxygen, scale, silver nitrate and birth certificates.

Q: Do you have a black bag?

A: No, I have an old suitcase with flowers on it. It's real dorky, every time I go somewhere with it people laugh. That's why I keep it I think.

Q: Are you licensed in any way?

A: No. There are lots of states you can't deliver babies unless you're a physician or certified nurse midwife. Neither Martha nor I is a nurse. Tennessee is one state that specifically exempts the practice of midwifery from the Medical Practice Act. We have a Tennessee Midwives Association, and I'm also a member of MANA, the Midwives Association of North America.

Q: What about hospital privileges?

A: There aren't any state laws against it, but direct entry midwives don't have privileges here.

Q: Direct entry?

A: That's what people call midwives like me. They used to call us lay midwives.

Q: Do you have malpractice insurance?

A: No. I don't know any midwives that do. And I don't know any midwives who've gotten sued.

Q: Is there any move toward licensing?

A: In this state, not that I know of. This is a traditional state. A lot of our legislators were born at home. Or their parents were born at home. Most of my neighbors were born at home, too. They don't think that's so removed. My mother was born at home, it's not that far removed even where I'm from. Mountain women almost all go to the hospital now because it shows that they're doing a little better than their Mama was doing.

Q: A symbol of upward mobility?

A: Yeah, things getting better, progress. Technology.

Q: How long have you been at it?

A: Twelve years ago I saw my first baby born. And I've been doing this ever since.

Q: Where were your kids born?

A: At home.

Q: Who delivered them?

A: I did—with the help of two women from North Carolina, a doc and a midwife. One each.

Q: You were already a midwife?

A: Yes. But it's different to do it than to watch other people do it. Inherently different. Someone asked me later if she thought I was a better midwife. I had to answer that every time I had left a birth before I had kids I thought, 'Oh, I wish that had been me. Wasn't that great.' Afterwards I'd leave a birth thinking, 'Oh, she did great. Boy am I glad that wasn't me.'

Q: What do you do about prenatal care?

A: Other than the lab work, we do our own prenatal care. We recommend that people see a doctor also. If by chance something happens, and they need to go to the hospital, I think it's better to know the person who's going to help them have their babies.

Our prenatal visits are long, usually two or three hours. We check blood pressure and urine, feel the position of the baby, measure fundal height, listen to fetal heart tones. We sit, drink tea and talk. The more that we are comfortable with each other, the more comfortable we'll be in a labor situation. I always feel by the time the birth happens we're part of the family. We ease out of the family as they need us less.

We talk about how the process of giving birth is supposed to work. We recommend women read and read and read. Mostly it's a matter of getting families educated so they're ready to do it on their own. The other thing that we recommend strongly is for people to eat well, because most people who eat well don't have problems. If any problem starts to happen we attack it nutritionally. That's really the best key to turning things around and keeping them healthy.

I recommend raspberry tea to everybody because it's specific to the uterus. Raspberry leaves are real high in vitamins and minerals. The Native Americans believe that it eases childbirth. I think that's true. And I also recommend strongly that they drink nettle tea in their third trimester because it's so high in vitamin K and calcium. Very few people who drink nettle tea bleed too much.

We expect optimum nutrition. We do a lot of nutritional counseling. It's not that we expect people to start out having this perfect diet, but we ask people to work with us. No liquor, no coffee, no cigarettes. One of the cardinal rules I have, I don't do people that smoke. Because I think if you're going to smoke you shouldn't be at home. You're creating a situation that could need special assistance. And while I think that birth is a normal healthy thing, and I do believe that, I think you also have to take care of yourself.

Q: Do poor women have trouble affording the diet?

A: Well, no. A lot of a good diet is going to whole wheat and beans and whole grains. Beans and rice are pretty accessible to people of most income levels.

Q: Who are your clients?

A: People who want to have their babies at home are a mixed group. Some want babies at home because it's less expensive. Others hated the way they were treated at the hospital.

Lucinda Flodin, Midwife

Q: So this might be their second or third baby?

A: A lot of times. Some are the back-to-the-land kind of people, people who've taken their lives back in their own hands. We do a lot of babies for fundamental religious people. They're definitely looking for a spiritual aspect they don't think they can get in a hospital.

Q: How much do you charge?

A: It varies depending on how much time we spend with the person, when we hook up with them. We never let money be the issue that keeps them from having us. We've done babies for quilts and food and babysitting. It's a lot more economically feasible to have your baby at home, it's maybe $700.

Q: That includes prenatal?

A: Everything, prenatal, labor, delivery, postnatal and well-baby checks. Usually we do the last checkup six weeks after the baby is born.

Q: How do people find you?

A: I don't know. It's one of the more amazing things.

Q: How many births have you done?

A: Maybe 125. About 10 a year on the average.

Q: How's the relationship with doctors?

A: It's been very good around here. A couple of the docs have been open to working with us, talking to us. They're not pro-home birth. I don't think they're supposed to be. But they'll give backup. But some have not been very nice to us. I used to get intimidated by that, but that was years ago. I remember taking one woman in who needed to be in the hospital and having the doc send down a message that he wouldn't see her until we'd left the hospital. It didn't allow that we knew more of what was going on to that point than he did and wouldn't that information have been helpful? But I guess he thought we were ignorant.

Q: Talk about cesareans (the surgical delivery of a baby).

A: In the end you get a baby. But it's harder.

Q: Even though it's not as painful?

A: It is as painful. You may not have the pain right then, but you're going to have more pain afterwards than you would have with a regular birth. In a normal birth, once the baby's born, you feel great. After a cesarean, you've had major surgery, and you feel bad for a long time. The few times I've been in a cesarean birth it was a real difficult experience for the women. They didn't want to have C-sections, so it was hard, having to deal through feelings of failure. And real sorrow. Sadness.

Both the sections I watched I was their hospital labor coach. One of them had a section before and was trying to avoid it. She didn't really want to be at home, but she knew that she needed an advocate, which I think is a good idea—in any hospital birth.

Q: Why is that?

A: Because it's a tense situation in a hospital. Everything is out of her control. Every intervention tells her that she knows nothing about what's going on and can't trust her instincts—so she can't yield to the power of birth. She is not giving birth, or delivering herself, she is being delivered.

One of the things that seems so bizarre to me in the hospital is you've got birth being run mostly by people who can't do it. There's something wrong about that. I think that medical people have forgotten that their best teachers are the women who are giving birth. It's a mutual education. Obstetricians don't give birth. OB's don't deliver. Midwives don't deliver. Women deliver their own babies. And what the rest of us try to do is to keep them comfortable and guide the baby out so the baby doesn't fall on the floor and get hurt.

I think we as midwives are successful when, at the end of birth, the woman says, 'I did that, and thanks for helping me.' When she says, 'I couldn't have done it without you,' I know we haven't done our job well enough or she would take the credit she deserves. She, after all, does all the work. To me, the midwife's job is to give the power back.

Q: What would you change in a hospital?

A: I think some of the changes are happening because women are demanding them. Birthing rooms are an improvement.

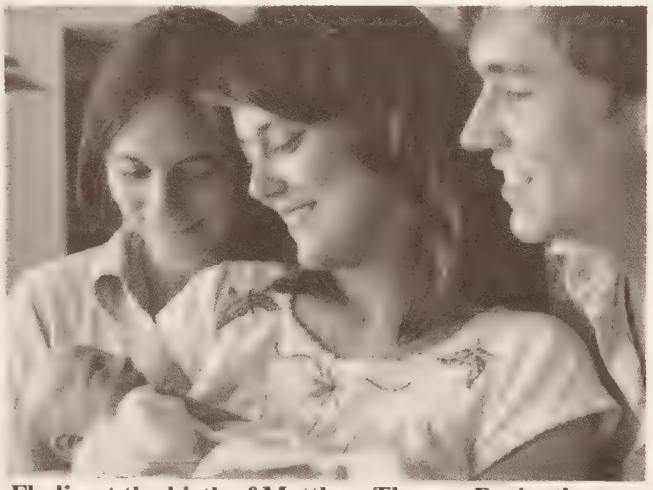
Q: What about inducing labor?

A Babies tend to get born when they're ready. It depends on why they get induced. I did a birth on a lady a year ago, she had sex one time and got pregnant. She knew exactly when she got pregnant because she hadn't had sex for a year beforehand. Well the ultrasound said that she was due on one day that was five weeks earlier than she said she was due. The ob/gyn was driving her crazy, saying, 'Well, we're going to induce you because you're getting late.' She kept saying, 'I'm not because my baby was conceived on this day.' But he was much more willing to believe his test than her word. It was a big baby. That's why it was big on the ultrasound.

Q: What about fetal monitors (the machines that monitor the heartbeat of the fetus)?

A: I don't like internal monitors at all. They force the woman to lie down. They put a timetable on her labor because they open the baby to infections. But some hospitals are doing better, they may use the external monitors for just five minutes an hour.

We are able to listen to the baby's heart tones at home. I carry a hand-held fetalscope (a stethoscope-like instrument used externally). Bonnie doesn't



Flodin at the birth of Matthew Thomas Borin, the second birth she ever attended, June, 1977.

carry a fetalscope. She listens with her ear or just listens intuitively.

I think the greatest thing that Bonnie has taught me is an inherent trust and faith that birth works. Babies get born. It's a good system. It's a system that works. And I don't think it works better because of modern obstetrics. Some things work better. But more often obstetrics gets in the way of the process by trying to fit it into a mold, a graph, a machine.

Home is at least as safe, sometimes a safer option, than the hospital. There was a large controlled study of people who planned home births compared to a group of upper-middle-class women who gave birth in the hospital. This was done by a psychologist, Lewis Mehl, in Madison, Wisc., in 1977. He found that in the hospital births there was eight times more shoulder distocia (the baby's shoulder gets hooked under the pubic bone), three times more post-partum hemorrhage, four times as many babies who got infections and 30 times more babies who had birth injuries related to delivery. There were three times more C-sections, nine times more episiotomies, nine times more severe—third or fourth degree—tears. Less than five percent of the mothers at home had analgesia or anesthesia, and 75 percent had them in the hospital.

Q: Have you ever had to carry someone to the hospital?

A: Yeah, a couple times. We've only transported one woman from a home birth to a C-section. We've transported for other reasons too.

Q: How do you account for the low rate of C-sections among your clients? (Cesareans account for almost 25 percent of all births.)

A: They take good care of themselves. They believe that the process works, and it does. Statistically it should work 94 percent of the time. I think that people should be at home only when everything is normal. Everything's going all right.

Q: You are taking a low-risk group.

A: Oh, absolutely. We don't do high-risk at home.

Q: Does that include age?

A: No.

Q: That's called high-risk.

A: I know it is, but I think that women can have babies as long as their bodies are capable of having them. Also, many women are in much better health when they're older than they were at 23. Sometimes it takes a little longer for women who are supposedly 'old' mothers. I was an old mother. Women have their babies, if they're lucky, when they're supposed to. I don't think age is a risk factor in and of itself.

Q: How was it that you moved to East Tennessee?

A: I came to Johnson City to start a theater company in 1974. Then I went to work for the Road Company (a touring theater company). When I first got here I felt like this was where I was supposed to live. I felt like I was from around here even though I wasn't born here. So I never left. My mother thinks I live in the wrong century. She's right. I do. I probably live about five centuries off as near as I can figure it. I do like some of the modern conveniences. I like having a car. I'm not totally out of this century. I just like the idea of families doing their own lives and growing and building community and being strong and doing things themselves. Though I certainly don't think you have to do every single thing yourself. I like the idea of helping each other, but I also like the idea of being the person who's producing my life rather than having somebody else take it out of myself.

Q: You're pretty self-reliant.

A: Yeah, reasonably. I do love my car. But I really like to grow my own food. I like raising my own kids. I like to educate my kids myself. I liked having my kids myself rather than having somebody else do the work for me. And I really hope, when I get to that time in my life, I hope I die at home. I'm not afraid of that. Sometimes I am.

12:02 A.M.
Clarence Bush's Systems Report

Whispered footsteps
In the attic? Subtle
Subterranean pulse, the
Midnight Overland Flier
Slowing for Clarence Bush
Steam engine uncoupling
Jarring the darkness
Switch engine,
Cardiovascular system
Jumping a track,
Disrupts the
dark.

—Walter Darrell Haden

Archives of Appalachia, East Tennessee State University

Walter Haden was first published in ***Ranch Romances*** *in 1947. He is with the Department of English at the University of Tennessee at Martin, and teaches at the Governor's School for Tennessee Studies at ETSU in the summers.*

HEALTH IN APPALAC

Dr. R.V. Tokar, company doctor, making a house call, McDowell County, W.Va., 1946. Photo by Russell Lee. From the National Archives.

Company-owned hospital, Harlan County, Ky., 1946. Photo by Russell Lee. From the National Archives.

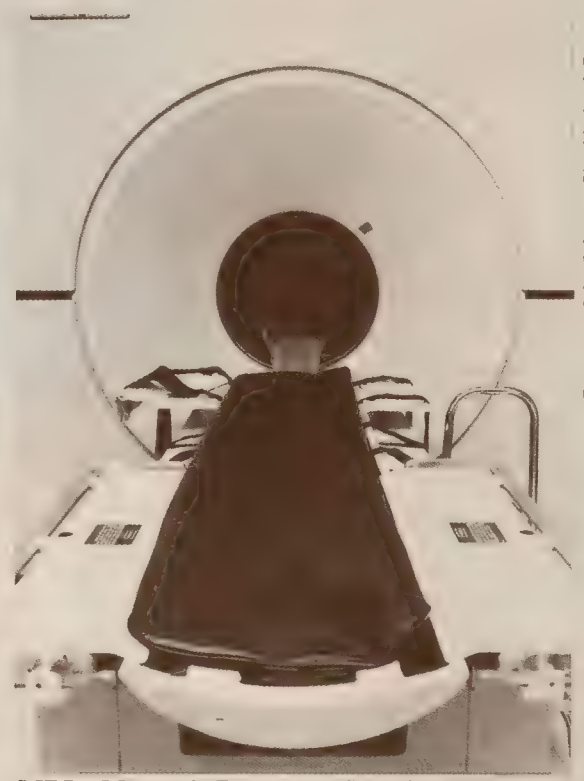
Erwin, Tenn., 1988.

Dr. Tokar on a house call. The doctor had to leave his car at the foot of the hill and walk the last quarter mile, McDowell County, W.Va., 1946. Photo by Russell Lee. From the National Archives.

Southwest Virginia, 1988.

HIA NOW AND THEN

Johnson City Medical Center Hospital, Johnson City, Tenn., 1989.



Courtesy of the Johnson City Medical Center

MRI—Magnetic Resonance Imaging, the latest in medical technology, comes to the mountains, 1989.

Pat Arnow

Johnson City Medical Center team.

Archives of Appalachia, East Tennessee State University

First autopsy observed by six freshmen nursing students

Students shroud the body,
pincer string and tags, read instructions—
like paint by number, the art not so true.
They've known all along death exists,
but the room shades a darker quiet separate
it seems, from the hospital.
Feel the whole room listen.
Feel the body not listening.
Hold the foot and it feels dead
the way a zero must feel to itself.
Down to the morgue, like any other,
the elevator is prepared to be serious.
Eyes busy among themselves.
Students face the solidity of the huge door,
the hermetic clang behind.
The pathologist has already begun.
Breasts press the face out of sequence,
yellow fat upturned against brown skin like a fault.
He's jolly with his selection of knives,
chooses one from the xylophone order of longest to shortest.
He goes down down into the ark of ribs,
digs the chest into the emptiness of a giant spoon.
He suctions the fertile blood.
Every eye fastens to its level lower,
concrete pool draining its darker hue after season,
at bottom no buried treasure no soul disclosed
only cupped grave.
Organs pile like New England stone.
"Like beef," one student whispers.
The spleen silks across the Ouija board of the tray.
Glances criss-cross like those of convicts planning escape.
The pathologist explains the body's punctuation of valves,
rounds and lobulations, the microscopic waterworks of the
  kidneys,
and the stomach that resembles a small swaddled babe,
parallel to where a babe would be held.
The liver cleaves into an irregular deck of cards.
He scratches his neck.
A blood smear marks where to itch again.
The spleen indicates the edge of the tray.
A water hose aimed through auricles and ventricles,
the students are shown how the heart works—
yours, poet, no different.
He locates the sinoauricular node where the heartbeat begins.
It is electrical does not require the brain,
loves without reason.
The spleen springs forward. The sink captures the bird of it.
The whole half dozen students result one foot further
  from the table.
Intestines dangle from his arms,
twenty-four feet of them dangle from wrists and elbows
to dollop into a bucket.
"Hey, I'll be eating lunch after this."
The lungs, last to be examined,
clot with what went wrong.
Equation solved, the students merge the exit.
The marvel of their walk,
their bodies extend into their children.
Hats like haloes, their white shoes neatly erase footsteps.
They swing open glass doors. All outdoors becomes sky.
Eyes spill what they see the houses and cars myriad colored
movement everywhere hope not contained by stop signs,
cross-stitch of streets, or diaphragm of atmosphere.

—Hilda Downer

Hilda Downer is a psychiatric nurse at the Cannon Center in Banner Elk, N.C., and she is finishing up a master's thesis on ***Paradise Lost.***

Night Comes to the Chromosomes

Pamela Zahorik

Harry M. Caudill is a professor of history at the University of Kentucky, with a background in law and experience in the state legislature. He has written about the Appalachian condition for more than 25 years. ***Night Comes to the Cumberlands,*** *published in 1962, was a groundbreaking work that brought the problems of Appalachia to national attention. Subsequent writings have delved more deeply into the forces that kept the region a "colony" within the United States. The majority of his work centers on the social and economic development of the Cumberland Plateau, with results that are both thoughtful and illuminating.*

Mr. Caudill also returns to another theme with alarming regularity. That theme is the destruction of the Appalachian people through the deterioration of their collective genetic pool. According to Caudill, this is coming to pass through two processes—the loss of desirable individuals (and hence their desirable genes) through an exodus from the region and the rising incidence of diseases through biologic and environmental factors. We asked medical anthropologist Pamela Zahorik to address these issues.

"In some communities the blood lines are so few and so intermixed that the most patient genealogist might lose his wits in attempting to unravel them. The inbreeding with its attendant genetic pitfalls contributed much in later years to the erosion of the highlander's self-reliance," Harry Caudill wrote in *Night Comes to the Cumberlands*.

In that book he also said, "These rangy, narrow-minded, stubborn, clannish men and women continued to multiply with all the astounding efficiency which has marked their history in the Southern hills."

There is an inherent danger in the statements Caudill has made. It is the danger of a "grain of truth" behind many of his statements which then leads to distortion of facts. For a generation these consistent inferences drawn from bits and pieces of correct information have led to erroneous conclusions.

I have probed three aspects of Caudill's more damaging hypotheses about Appalachia: the idea of inbreeding and its pitfalls, the rise of specific genetic conditions, and that these factors, along with an outmigration of the motivated and the strong, have resulted in a population suffering from chronic, passive dependency.

Inbreeding is not exclusively an Appalachian phenomenon, nor is it necessarily an undesirable one. All societies have rules restricting marital possibilities. These patterns of preferential marriage, based on caste, class or religion, shape a population as much as geographic isolation. For instance, in Japan, first-cousin marriages have been arranged for centuries. There is a well-known pattern of intermarriage in upper classes of many countries. Ideally patterns of mate choice—and their genetic consequences— should be viewed with an equal eye in all of these situations. Their existence must be credited to strong cultural determinants, not ignorance.

It is true that any isolated, inbred population runs the risk of increasing the incidence of genetically-determined diseases. However, Harry Caudill has made some broad assumptions based on data that he has misinterpreted.

Caudill wrote this year in the Whitesburg, Ky., *Mountain Eagle*, "It has been written of Eastern Kentucky that it is the sickest part of America. By that it is meant that the region has the lowest general levels of public health...The diseases that ravage human health are of two categories. Some are genetic or inborn, and others are caused by factors in the environment...One of the genetic ailments is called Huntington's chorea and was sometimes known to our ancestors as the 'jerks'...much of the overt insanity now found in the mountains results from this inborn curse. In any event its prevalence in eastern Kentucky is higher than in the United States as a whole."

It is difficult to find supporting data for these statements. For instance, can Caudill give any solid evidence that standards of public health are lower in Eastern Kentucky than in urban ghettos? Every population will experience varying states of health dependent on changing genetic and environmental factors. Yes, these factors should be isolated and attended to. But it is an exaggeration to label Eastern Kentucky as the "sickest part" of America.

Caudill also makes a fallacious assumption when he says that Huntington's chorea is a scourge of Eastern Kentucky. The U.S. Department of Health and Human Services states that mortality from this disease is evenly distributed across the country. Caudill refers to Huntington's chorea as a genetic (do I read "inbred?") ailment. This is true. However, inbreeding does not increase its prevalence. Huntington's chorea is an autosomal (non sex-related) dominant trait. Only one gene, contributed by either parent, is needed for the expression of the disease. If you carry this trait, no matter with whom you choose to procreate, your offspring have at least a 50 percent chance of developing this condition. Studies in population genetics indicate that over time the number of people in isolated communities who get the disease will decrease.

The real problem in inbreeding comes from recessive genes (in which expression of the disease can only occur when a deleterious gene is contributed by each parent) as opposed to dominant genes (only one gene from either parent needs to be present for expression of the disease). These rules of genetics work in both directions. Inbreeding offers not only "genetic pitfalls" but allows the increase of desirable traits as well.

In the *Mountain Eagle* story, Caudill says he gets his information from an article in the Lexington, Ky., *Herald-Leader* which cites inbreeding in Eastern Kentucky as a cause of many birth defects. Dr. Bryan Hall, a geneticist at the University of Kentucky, is given as the source of this information. In a recent

phone conversation, Hall clarified his remarks. There are instances of rare recessive genetic disorders in Eastern Kentucky, he has found, and when counted as a group they result in statistically significant rates. The consanguinity (inbreeding) rate in rural Appalachia is about 7 percent as compared to an overall rate of .5 percent in the U.S. However, he pointed out, rates of 20 percent are recorded in island populations in Finland, and upward to 50 percent in other parts of the world.

But the ramifications of this level of inbreeding in Appalachia is small compared to the impact of environmental factors. Water pollution, inadequate sewage and occupational hazards are a much greater menace to the health of this population than any genetic defects. The National Institutes of Health report that elevated mortality rates occur in Appalachia due to diseases of poverty including tuberculosis, gallstones, and some congenital anomalies.

Harry Caudill has done much to bring public attention to the environmental and occupational hazards of Appalachia, and this is where public health efforts should be concentrated. Unfortunately he is also doing much to imprint on the American consciousness the notion that Appalachians come from inferior stock.

Some health care professionals have embraced Caudill's genetic theories and reinforce them with anecdotal evidence. I was told by several people about particularly high rates of specific conditions they have seen in the area. Maple syrup urine disease and Alzheimer's were two. When I contacted the national organizations for these illnesses, they told me that there are no central data banks, and they were unaware of any regional patterns. There might be truth to this anecdotal information, and formal investigation should certainly be undertaken, but the myth of Appalachia as a teeming genetic disaster area should not be perpetuated. Caudill popularized the image, and others use his groundwork as a frame of reference.

In an interview conducted by Jerry Williamson and Stephen L. Fisher in *Appalachian Journal* in 1981 Caudill restates this conclusion: "I've discussed it with numerous scientists—we have had a whole string of out-migration in which the stronger and more ambitious people get up and leave. And the result is an increasing passivity on the part of people."

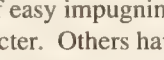
Ambition, poverty and resignation are not predetermined characteristics. Neither are they transmitted through lamarckian principles (characteristics acquired by habit, use or disuse which may be inherited). Lamarck, the 19th century biologist, was wrong, and Caudill is wrong to insinuate that the people of Appalachia are what are left of poverty-prone ancestors and individuals without enough gumption to leave the region. Certainly many individuals choose to remain in Appalachia, ambition intact.

Caudill wrote in *A Darkness at Dawn* in 1976, "Many deeply-rooted attitudes that still give rise to poverty and resignation may have been instilled in the mountaineers' ancestors during the centuries preceding the first English voyage to the New World."

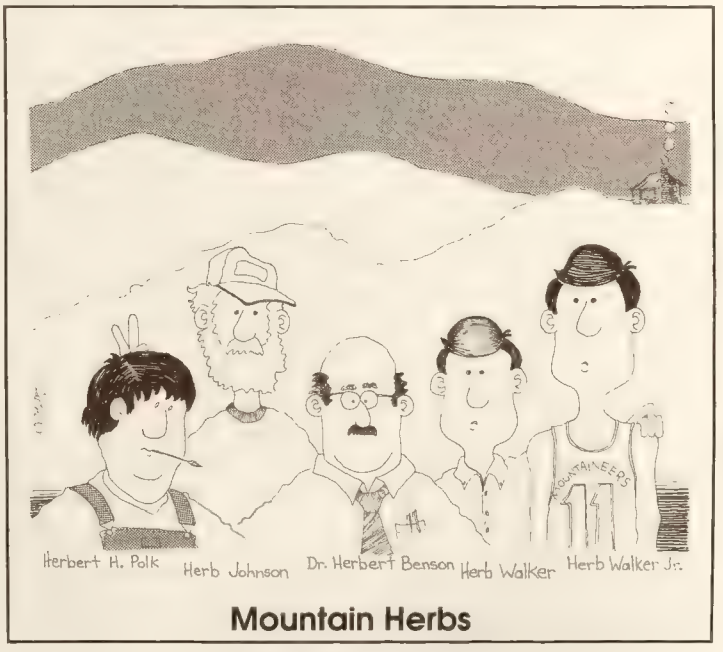
Anyone who dared attribute the social problems of any minority populations to genetic factors would immediately be labeled a racist by the mainstream academic community. But Caudill has gotten off easy impugning the Appalachian character. Others have taken him to task. Jerry Williamson in the *Appalachian Journal* interview asked, "You don't understand why people have objected to what you've said about the mountaineer and his genetic heritage. Isn't it pretty clear why they have objected, if you are suggesting that they are determined before they're born to be a people without will and ambition, people who are almost supine in the face of any power other than themselves?"

Caudill replied, "Well, they may object. If they do, they just object. You know, I think that's the truth...if somebody objects to what I think is the truth, I don't object to his objecting, I just ignore it, because the truth transcends...and part of the supineness and the apathy and the passivity of mountain people is due the fact that the strong and the smart have gotten up and left, generation after generation."

As a scholar who obviously cares deeply for the goals and objectives of his research, Caudill has a responsibility to lead his readers to the whole "truth." Once information makes its way into print, and especially when it arises from the pen of a recognized expert, it is open to endless quotation with the often undeserved endorsement of respectability backing it. We should not provide undocumented information for those who come after us, for the result, albeit unintentional, is the creation of a false stereotype of a region and its people.



Pamela Zahorik is a research associate in the department of family medicine at the Quillen-Dishner College of Medicine and assistant professor in the department of Sociology and Anthropology at East Tennessee State University.

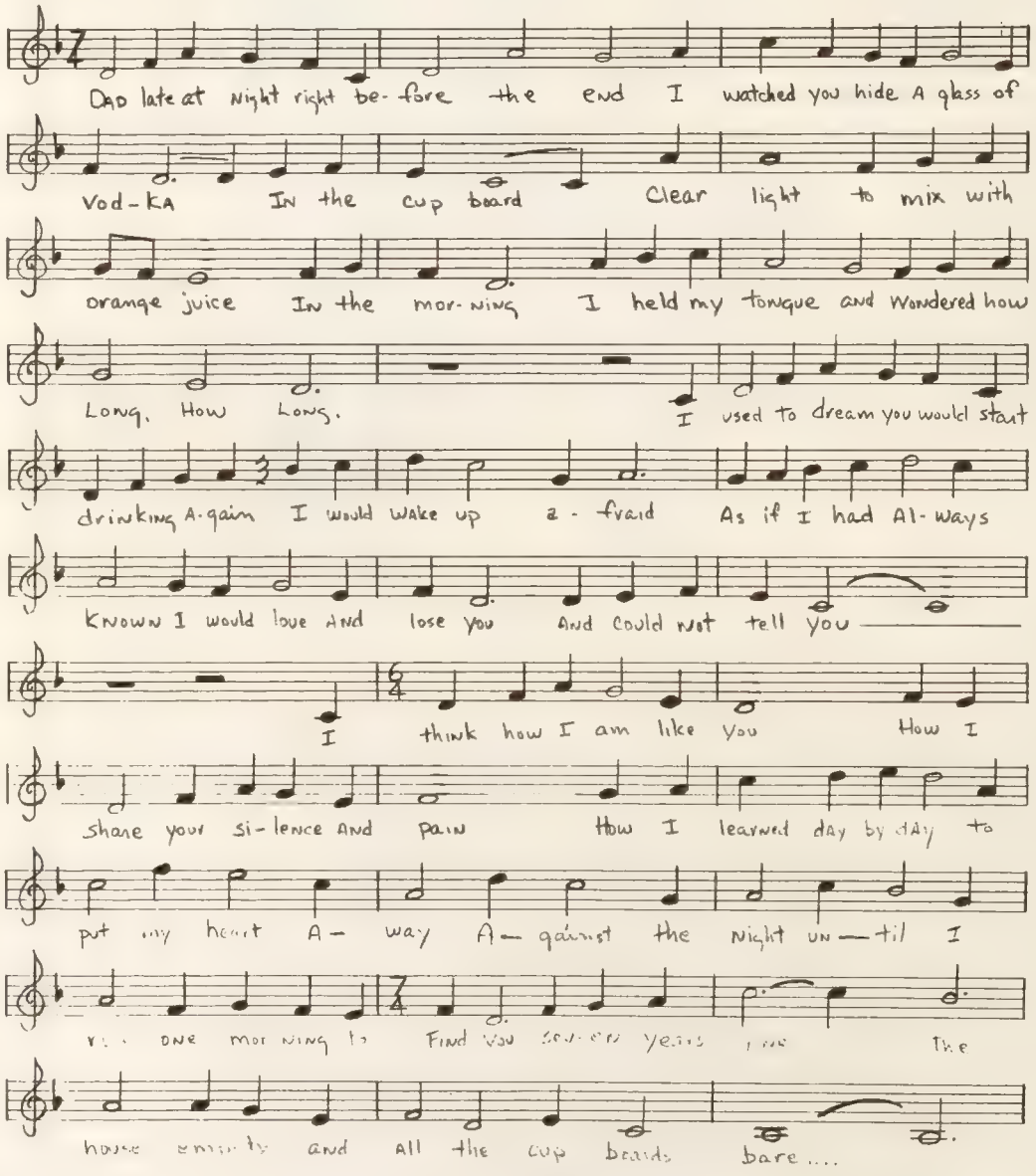


Denial

Steve Lyon

The song "Denial" was written by Steve Lyon from Lexington, Ky. Steve plays keyboards and has recorded for Flying Fish Records; his album is titled "There's No Place Like Mars" FF306. He sent along this introduction to "Denial." —*Ed Snodderly*

When you live with alcoholism, denial becomes the fabric of daily life. It's the thread that binds things together, a seamless garment that holds the whole family. And it is woven anew every day with every breath. No wonder it fits so well. It fits so well that it becomes invisible, unquestioned. Second nature. First nature. Just nature. It is just the way things are. To begin to come out of it you have first to see that it exists, and that can take a long time. That's what this song is about.


Dad late at night right be-fore the end I watched you hide A glass of
Vod-ka In the cup board Clear light to mix with
orange juice In the mor-ning I held my tongue and wondered how
Long. How Long. I used to dream you would start
drinking A-gain I would wake up a-fraid As if I had Al-ways
known I would love And lose you And could not tell you
I think how I am like you How I
share your si-lence And pain How I learned day by day to
put my heart A- way A- gainst the night un-til I
one mor-ning to Find you sev-en years The
house empty and All the cup boards bare....

Rx: Stumpwater and Streptomycin

Urban Appalachian Health by Phillip Obermiller

Some seven million people left Appalachia in the past 40 years. With large numbers of first- and second-generation Appalachian migrants now living in major metropolitan areas of the United States, urban health care providers have a greater need for accurate information about the cultural background and special health concerns of urban Appalachians.

While health issues and service strategies in the Appalachian region are reasonably well documented, less is known about the health problems and the accessibility of medical services for urban Appalachians. Much of the information about urban Appalachian health concerns is dated, obscure, or appears as incidental sections of larger reports, but the results of four studies provide some useful insights on the topic.

Virginia McCoy Watkins, an Appalachian migrant from Virginia, studied urban Appalachian health care needs while a graduate student at the University of Cincinnati. In her 1973 masters of sociology thesis, she notes the key roles of home remedies, folk medical practices and faith healing in the migrants' background. Modern medicine is not unknown in the mountains, but is relatively difficult to obtain. Few opportunities for nutritional education or for preventative health-care measures are available. Watkins points out that in the mountains health care is generally sought only in a crisis. Medical procedures under emergency conditions are drastic, impersonal and frequently ineffective. This unfortunate situation, usually accompanied by unfamiliar bureaucratic forms and procedures, fosters a fear and suspicion of health care providers that Appalachians bring with them into urban environments.

John Friedl, an anthropologist at Ohio State University, interviewed 51 providers and 106 Appalachian migrant families in Columbus, Ohio, about health-related topics in 1978. His findings in a report prepared for the Department of Health, Education and Welfare are consistent with Watkins' He finds that the rural health care experiences of Appalachian migrants leads to certain unfulfilled expectations of urban health care providers. The physician in the mountains has fewer staff resources and therefore more direct contact with the patient. Because of cost and travel time, referrals to distant specialists are rare. For similar reasons the mountain physician is more likely to try for a "one-shot cure" rather than a series of treatments. Drugs are more frequently distributed at the time of treatment rather than by prescription. Third-party payments are less typical in rural areas, so fees are lower and payment schedules more flexible. The obviously contrasting styles of health care service in rural and urban settings often lead to confusion, distrust, and negative stereotypes on the parts of both the Appalachian migrant and the urban medical provider.

Children of Lower Price Hill, an Appalachian neighborhood of Cincinnati, 1989. Photo by Tim Boudreau.

Tennessee-born Lonnie Helton is a medical social worker in Cincinnati who has first-hand experience in assisting fellow urban Appalachians obtain health services. In a recent article in *Mountain Life and Work* he notes the endurance among migrants of folk remedies such as catnip tea for bellyaches, turpentine poultices for bruises, ginseng tea for weight loss, radishes for wart removal, baking soda and buttermilk paste for poison ivy and water from decayed tree stumps for removing freckles. Rather than adding modern medical technology to this repertory of folk wisdom, many urban health practitioners shame their patients by ridiculing these unfamiliar practices. Others have difficulty understanding the emotional survival mechanisms built up over generations of subsistence living. Helton observes that middle-class doctors and nurses, accustomed to vigorously attacking diseases, cannot easily accept Appalachian reserve and resignation in the face of grave medical diagnoses.

While some health care professionals have been made aware of the special health concerns of Asians, Hispanics and blacks, other culture groups are not as easily identified, nor is consciousness of their culture as widespread. Helton finds this insight particularly true in the case of Appalachian migrants:

"I am often shocked and dismayed by the lack of understanding and seeming disinterest in learning how to better serve urban Appalachians...A foreign intern was recently chided and teased by colleagues for expressing an interest in attending a seminar on Appalachian culture. One resident admitted to having some baseline data for understanding blacks but admitted that he absolutely 'didn't even know where to start in trying to figure out Appalachian people and their motives.'"

John Friedl, writing in *Appalachia and America: Autonomy and Regional Dependence* (edited by Allen Batteau and

published by the University Press of Kentucky in 1983), astutely observes that this cultural division between providers and patients has two sides:
"...the professional jargon and middle-class educated speech patterns used by health care providers create a cultural gap between them and many of their clients, including Appalachian migrants...Among recent migrants, different names for health problems are often used which are not understood by non-Appalachian physicians, nurses, and other professionals. Even accents and speech patterns can create serious barriers to effective personal interaction in the health care setting."

A colleague at the University of Cincinnati, Robert Oldendick, and I recently completed a comparative study of urban Appalachian health concerns and behaviors. Results were presented at the third annual University of Kentucky Conference on Appalachia: Health in Appalachia, in 1988. Interviews were conducted with 512 randomly-selected residents of Cincinnati who were asked questions about their current health status, health-related concerns and health-care activities. We separated the respondents into three groups for comparison: white Appalachians, non-Appalachian blacks and non-Appalachian whites.

We found that urban Appalachians have the same low socioeconomic status as urban blacks, and express similar concerns about general health risks. However, a rank ordering of health concerns by culture group indicates that Appalachians have health priorities that are distinct from those of the other two groups. Blacks and non-Appalachian whites indicate cancer and heart disease respectively as their first and second health concerns. Appalachians, on the other hand, report heart disease first, accidental injury second and cancer third as their primary health worries.

Appalachian concerns about heart disease can be linked to their high rates of smoking. The concern about accidental injury may be related to the fact that many Appalachians have experienced the perils of working in the central Appalachian coalfields and driving on dangerous mountain roads. In addition urban Appalachian workers are frequently employed in manufacturing and service jobs with high incidences of occupational hazards.

We also discovered that urban Appalachians have the same knowledge base as other city residents about the consequences of smoking, regular exercise and proper nutrition. However, they are nearly twice as likely to be smokers as the black or other white respondents. We attribute this finding to the fact the most Appalachians have roots in a rural region whose main cash crop is tobacco. The use of tobacco products is not only socially acceptable among mountain men and women, it is also widely perceived as critical for economic survival.

Our study indicated that urban Appalachians have a distinctly low opinion of genetic influences on overall health, and are similar to urban blacks in their belief that good health is a matter of luck, and that illness is caused by God. We associate these opinions with the fundamentalist religious beliefs typically found in the Appalachian region and throughout the rural South. Concepts of genetic mutation and inheritance are closely linked with arguments for human evolution, a scientific tenet that conflicts with literal interpretations of the Bible. Similarly, in fundamentalist belief, the hand of God is directly involved in human affairs including punishment through illness and forgiveness through healing.

The evidence from these four studies indicates that urban health care professionals would be remiss in ignoring the Appalachian heritage of their patients. Although some urban Appalachians are now two and three generations removed from mountain life and the migration experience, it is premature to assume that assimilation has completely eliminated a particular cultural perspective from their health care concerns and needs.

A basic knowledge of Appalachian history and culture on the part of health care professionals can do much to alleviate miscommunication, particularly in areas where professional and cultural assumptions come into conflict. As is the case with other groups of health care consumers, adding a cultural perspective to medical education can greatly enhance medical services to urban Appalachians.

Phillip Obermiller is director of the degree program in Applied Sociology and Anthropology at Northern Kentucky University. His main form of exercise is attending meetings of the Research and Education Committee of the Urban Appalachian Council.

Lines by a Moderator

You studied health and learned the rules
From all the books you had in schools;
Yet "moderation" is just a word
You think that somewhere you have heard.

You smoke all day like an ocean liner
'Til your dusky lungs think you're a miner;
But when your throat gets irritated
It's at the weather you're aggravated.

To your bed you're nearly a stranger;
Your nerves are shot, your mind's in danger.
Into your brain doesn't the thought ever seep
That what you need is a little more sleep?

Complain no more to me—why in tarnation
Don't you try using moderation?

—Lorene T. Wagner

Lorene Wagner was reared in Southwest Virginia and educated at the University of Chattanooga, Emory and Henry, Peabody and Duke. She taught junior high school in Chattanooga for 41 years. Now retired she lives in Appalachian Christian Village Towers in Johnson City where she takes piano lessons and participates in the activities of two small grandchildren.

A Quiet Revival

by Jane Harris Woodside

When it comes to health care in Central Appalachia, "There's a quiet revival of service," claims Chris Holsinger, a 22-year old Vanderbilt student. Two student-staffed programs—one decades old, one relatively recent—are supplying the young workers to staff health practices and programs in the small towns and rural areas of Appalachia, areas where doctors and other health care professionals are often a rarity.

Adrianne Bloom, a former Appalachian Student Health Coalition co-director, visits a project site in Southwest Virginia in the summer of 1987.

Currently taking a year off before entering his senior year, Holsinger is co-director of one such program, the 20-year-old Appalachian Student Health Coalition based at Vanderbilt University's Center for Health Services in Nashville. The Coalition recruits students from a variety of disciplines—from medicine, nursing and public health to psychology and English—to work on health-related projects in central Appalachian communities during the summer.

More recently, the Quillen-Dishner School of Medicine's Family Medicine department established an Appalachian Preceptorship in 1985. Located at East Tennessee State University in Johnson City, Tenn., the Preceptorship places medical students in rural communities for an average of five weeks of the summer to observe and work under the tutelage of practicing physicians. "The focus of this program is to get medical students into small, isolated rural practices to see what it's like to deliver rural health care in this region," explains Dr. Forrest Lang, Family Medicine department Vice Chair and Education division director.

Pre-med molecular biology major Holsinger worked on a project in Southwest Virginia last summer. He helped staff a cardiovascular screening and health education project in Norton, Va., and three adjoining counties. The students conducted screenings, referred high-risk patients to physicians and participated in community workshops on cardiovascular fitness.

Holsinger remembers in particular a Dungannon, Va., woman in her 50s whose tests revealed high cholesterol levels. "There was a chemistry between us. I really liked her," recalls the young volunteer. "I spent a little longer than normal talking to her about diet and exercise." A fellow Coalition worker ran into the woman later that summer and reported back to Holsinger that she was cutting down on her fatty foods, eating more vegetables, and walking 15 minutes each day. "My contact with that one person was valuable to her. And it was very valuable for me to know that," he says with satisfaction.

The Coalition models itself in accordance with the World Health Organization's definition of health as a "state of complete physical, mental and social well-being," a definition which takes into consideration economic, political and environmental factors. Holsinger has distilled it to his own concise definition: "I think health really is the power to work for your well-being."

Last summer, the Coalition conducted a series of health fairs targeted specifically at women. "The directors last year felt that women's health was a neglected issue," Holsinger explains. "Women generally focus on tending to their family's health, and often they neglect their own. Coalition teams traveled to various communities doing screening and talking about topics ranging from family planning, birthing, nutrition and AIDS to employment opportunities and interviewing skills.

Another project sponsored by the mental health center in Powell, Tenn., 10 miles north of Knoxville, worked on forging links between the center and nearby industrial work sites. Coalition workers went into factories to conduct health education workshops and to help organize worker health committees to identify and deal with health issues in the plants. In Kenova, W. Va., a suburb of Huntington on the Ohio River, three Coalition students assisted with the Tri-State Environmental Impact Groups with completing a survey to determine if frequently reported symptoms such as nose bleeds, vomiting and skin rashes were related to discharges from a large petrochemical plant in the area.

The Coalition traces its origins—by way of several organizational permutations—to the late 1960s. The size and scope of the program first expanded, then contracted as Federal funding sources started to evaporate in the mid-70s. Today, the Coalition has partially replaced Federal funding with a number of private foundation grants supple-

mented with support from Vanderbilt and the proceeds of their own fund-raising efforts.

Losing Federal funds, says Holsinger, "makes us really streamline our program." Their main strategy for maximizing their effectiveness is to work with existing community groups on projects the community originates rather than starting from scratch. Says Holsinger, "I think we realized that to work for long-term improvement of a region's health, we've got to just be resources—and be valuable resources."

Holsinger is aiming for a balance of Appalachian natives and outlanders to staff this summer's projects. Recently, he explains, most Coalition volunteers have come from the Northeast. At a week-long orientation at the beginning of the summer, the Coalition staff tries to help its volunteers confront their regional stereotypes.

Holsinger observes, "The strangest thing is that the stereotypes are not about Appalachia. They're about the South. A lot of the people from the Northeast are afraid everybody is going to hate them because they're Yankees. The students think people here are really close-minded, and everyone's fundamentalist. But I think all that dissolves because the people who do the Coalition are not interested in finding those things. They're interested in working with the community."

Tony Lawson, administrator of the community health clinic where Holsinger worked last summer, enumerated the benefits hosting Coalition workers had for his community. "By manning the screening program with students, we were able to reach a lot more people than we would have on our own. And I think it's revitalizing just to have some smart young people around. Bright students ask questions. It just forces you to think through what you're doing, to clarify why you're here."

Recharged by his year with the Coalition, Holsinger will return to Vanderbilt next September and start typing out his medical school applications. The Coalition "came at a time when personally I was looking for something in medicine that I was just not finding in my molecular biology classes. I didn't understand what I was getting into in terms of the political and social responsibilities of medicine. Being a molecular biology major, you focus on 'fact' supposedly. But you don't really understand how medicine works. Medicine is not just prescribing medicines or doing procedures.

"I was discouraged to see the profession mainly as a pursuit of a lifestyle for the doctors rather than a real commitment to improving people's lives. I was considering getting out of the profession. Working last summer was so inspiring because the community health care providers were really dedicated to what they were doing. Medicine wasn't just a way to a BMW. It was a dedication to service."

Quillen-Dishner's Appalachian Preceptorship places medical students in rural practices in places such as Roan Mountain, Tenn., or Saltville, Va., in order to give them exposure to rural medicine. At the same time, the program tries to give them an awareness of how the physician's ability to understand patients' cultural beliefs about their health is crucial to treating them effectively. The Preceptorship was conceived when Philadelphia native Dr. Forrest Lang first came to Quillen-Dishner. He asked himself, "Why should Vanderbilt out of Nashville be running an Appalachian program? ETSU, in the center of this area, was really doing very little in terms of focusing on the Appalachian region." By the summer of 1985, the Preceptorship had augmented its support from Quillen-Dishner with a grant from the Department of Health and Human Services and with two students, launched its first program in 1985. Currently they attract 12 to 15 students from medical schools all over the country each summer.

The Quillen-Dishner program does not duplicate the Coalition's efforts. "We don't get into any of the political or development issues that the Coalition gets into," says Lang. "The students that come into this program come into it for a clinical perspective, a clinical perspective that is different from what they get in medical school. It has to do with a better way to take care of patients."

Lang equates "Appalachian" with rural. He notes, "The real need medically for physicians is in small rural communities." Disparities abound within the region. For example, urban areas such as Knoxville, Tenn., have at least four times the number of physicians in proportion to the population as do rural areas of the region, such as Carter or Hamblen counties, Tenn. Lang hopes that by giving medical students experience in small rural practices—both in private practices and in publicly-funded clinics—they will perhaps decide to take up rural medicine permanently. "We try to let them know that they can go to some of the most isolated places, and they won't be medically isolated. They can be connected to a medical school, they can teach students, they can be connected."

Patricia Fine, now a second year medical student at Wright State University in Dayton, Ohio, worked for a month under the supervision of Dr. Michael T. Hood in Newport, Tenn., a family practitioner in a group practice with a patient population from a range of social and economic backgrounds. Although she spent most of her time observing Hood, Fine did assist him in suturing cuts, taking patient histories and conducting physicals, making rounds at the local hospital and spending a few nights helping him staff the local emergency room. At times, Hood allowed the student to go in and conduct the initial interview with a patient, then report her findings and conclusions to him.

Just as enlightening as her clinical experiences were the evenings she spend attending professional meetings and the long talks with Hood about the practical requirements and the business side of running a practice. She watched him practice subtle social skills she hadn't even imagined were necessary when dealing with his clients. When treating a patient from deep in the country, she recalls, Hood's twang deepened. "He said it was easier to communicate with them when he spoke in a way they understood," she recalled in a phone interview.

After the students have worked out in the community for a week or so, they come together on East Tennessee's campus for a week of lectures. "We never write that we're getting them together so they can cross-pollinate their enthusiasm, but that's really one of the major reasons for bringing them together," says Lang. The other major reason, of course, is to deal with regional culture. "Very few medical students get any formal education on the issues of culture in medicine," Lang observes.

Quiet Revival

Students learn about alternative healers and folk remedies, from herbalists and healers, such as Bluff City, Tenn., resident Jim Grey, who goes by the name of Catfish II, (his brother Clarence, also a healer, is known as Catfish Man of the Woods) or Chief Two Trees of Old Fort, N.C. Such folk practitioners take the medical students on field trips quite literally, tramping through woods and fields to find and discuss native medicinal plants. Or they travel to places such as the Wilcox Botanical Supply House in Boone, N.C., one of the world's largest suppliers of medicinal herbs and other botanical supplies.

The students discuss more general cultural issues as well. Lang finds rural Appalachian medical beliefs about natural cures and supernatural causation of illness distinctive. From a survey of Roan Mountain, Tenn., he concludes that a significant minority of people in rural Appalachia turn to natural remedies—potions, tonics and remedies from the earth—because there is a long time cultural tradition of using such means.

Religion also plays a prominent role in rural Appalachia's thinking about health and illness, says Lang. "Unless practitioners deal with these beliefs, they won't be able to completely help the individual."

However, Lang cautions that while beliefs in natural remedies and supernatural causes are found in rural Appalachia, they are not necessarily the norm. "People here have values that are pretty similar to people in Wisconsin or Oklahoma. Places like Kingsport and Johnson City are really in many ways suburban communities like many suburban communities around the country. So any kind of sense that Preceptor students might have that everybody here in Appalachia is the same, I think they quickly realize it's just not the case."

The same holds true for major illnesses. "It's heart disease, hypertension and diabetes you're going to see about the same as anywhere else." But there are some health difficulties further down the list that occur in this area more often than elsewhere. They include occupation-related problems such as farming injuries and pneumoconiosis or Black Lung, the respiratory disease found among miners.

When asked about the region's strengths, Lang replies, "People respect and like their health care providers. Where most communities have been without providers for a long time, they do seem to appreciate it more when a physician is there. Which has something to do, I think, with the people and their general openness and friendliness. You know, we have students from different parts of the country go walking around and get invited into houses and are made to feel at home. That would not happen in Washington or Atlanta."

The Appalachian Preceptorship is just the beginning of a more comprehensive effort on the part of Quillen-Dishner's Family Practice department to give future doctors exposure to rural medicine. "We hope we will be attracting students from this program into our residency and then for some selected residents who want to stay and get our Rural Fellowship." The rural fellowship, which begins July 1, allows the physician to earn a masters degree in public health administration while concentrating on rural health care. "And so, at the end point of this educational system, we would have a number of rural docs graduating who would be going into these areas and providing leadership in rural Southern Appalachia."

At this point, the program is too new—even the earliest participants have not yet finished their training—to tell how many of the Preceptorship students actually have made the decision to go into rural medicine.

Through their participation in these student programs, both Chris Holsinger and Patricia Fine are now thinking in terms of making a career of rural medicine. Says Fine, "People don't realize what need there is in rural areas. People need to be served."

Making the discovery that there are areas where real need exists, that their professional lives need not be spent in saturated markets competing with too many other physicians for too little business, has been an energizing and sustaining one for both Holsinger and Fine. As Fine says, "When I'm sitting here studying and getting sick of all the books, my experience last summer keeps me going because I really know I'm doing the right thing."

Jane Woodside is a research associate with the Center for Appalachian Studies and Services at ETSU.

Terminus

The suction machine groaned when
The plastic tube filled with red tissue.
This synthetic umbilical tube gulped
Life as if it were a cherry shake.

Her hips moved rhythmically, withdrawing
From the stainless steel dilator.
The probing metal wasn't as cold as before
And the pain was less sickening.

The dim back stairs shielded her.
Outside a cold mist ushered in Winter
pickets across the street yelled "Murderer."
But her horoscope said "Do as you must."

The father of the egg-sperm complex
Sat in the car and chanted
"Flower, flower, flower."
"Boogie" was stamped on the license plate.

—David K. Fenner

David K. Fenner practices internal medicine in Elizabethton, Tenn. His poetry appeared in an anthology of Appalachian writing, ***In Place****.*

MEETING THE CHALLENGE

A Highwire Act on the Qualla Boundary

Robert Gipe

"For kids on the reservation, it is too easy to grow up with no expectations and no fear. We try to give them a little of both."
—Tom Hill, director of the Cherokee Challenge

Toni Tahquette, an adventure counselor with a hairtrigger smile and eyes bright as black diamonds, recently gave a tour of the Cherokee Challenge rope and obstacle course to show how it can reinforce the spirit of cooperation and accomplishment in the clans of young Cherokee.

Cherokee Challenge is an adventure program designed to help the members of the Eastern Band of the Cherokee between the ages of nine and 14 grow up physically and psychologically healthy. The program does not set about achieving those goals with cod liver oil and calisthenics. They promote sound minds and bodies by sending the young Cherokee white water rafting down the Nantahala River or by teaching them the Green Corn dance and other native Cherokee traditions.

The first stop on the tour of the ropes course was a series of steel cables about three feet off the ground. They connected half a dozen trees in a clearing behind Challenge headquarters outside Cherokee, N.C. The clan members walk these wires, Tahquette explained, in preparation for the higher wires on up the trail.

"Before any of the kids get to move up onto the higher ropes, the whole clan has to get over this first set," Tahquette says. "They have to walk the ropes one kid at a time, and figure their own way to get around the trees without touching the ground.

"The first time we turn them loose on the cables, the kids with the best balance

Carlos "Fat" Cruz on the Cherokee Challenge ropes course. Photo by Kelly Thomas Hill.

zip right through and sit down over at the end of this part of the course. They laugh at the ones who don't catch on as quickly and ask us if they can go on up to the higher ropes.

"Then they figure out that nobody moves onto the higher ropes until everybody gets across the low ones—so they start helping each other out. You should see them—huddled up over there at the beginning of the course, plotting how they are all going to get over.

"The kids who can do it by themselves show the others where the rope is a little slacker or how to get over the tricky corners—and they act as spotters for the ones walking the ropes—helping each other out until the whole clan gets across."

The clans are each made up of six to 10 children and are often named after the original clans of the Cherokee Nation. It usually takes each clan three afternoons to complete the obstacle course. The highest cables on the course are strung 35 and 40 feet off the ground. At those heights, every child is attached by a guideline to a spotter called a "belayer" on the ground. The belayer manipulates the rope that attaches him or her to the high wire walker up in the trees to help keep that walker's balance.

Confidence in one's belayer is of no small importance when one is crossing a cable stretched between two trees 40 feet off the ground. Confidence in oneself is not wasted at that height either. Thus the obstacle course is a cornerstone of the Challenge program, which aims to help its members, the future of the Eastern Band, learn to believe in themselves and each other.

Carlos "Fat" Cruz, a nine-year-old veteran of the ropes course, gave cheerful assent to the fact that trust can help overcome fear on the high wire: "Yeah, it's scary up there, but once you know the person on the ground is not going to let you fall, then you can do it. Then it's fun walking around up there in the trees."

We did not get to see anybody walk the ropes on the day we were in Chero-

kee, but Tahquette assured us it was pretty gratifying to see a formerly shy eleven-year-old girl come off the high wires, her face beaming with her achievement, awash in the cheers of the rest of her clan.

But according to the counselors, another equally satisfying part of the ropes course for them is seeing the children learn that they have to support each other and celebrate each other, regardless of the size of their accomplishment. The clans are taught that everybody who tries deserves a cheer, in hopes that all will catch the contagion of positive reinforcement.

"With some of them, if we can get them to climb the tree or stand out on the platform up there, that's great. That's plenty," says adventure counselor Sally Martin-Gantt. "Just getting up the nerve to climb the tree is a big accomplishment for some of these kids."

Through the gentle reminders of their adventure counselors, the young clan members are brought to realize that the personal *and* the social skills they learn up in the trees must be applied back on the ground, for at school and at home, caught between Cherokee and Anglo culture, these young Cherokees walk the tightrope everyday as they face an uncertain and often perilous future.

Depression, violent behavior, substance abuse, teen pregnancy—potential problems for all American youth—often develop out of the lack of self-esteem or confidence typical of adolescence. But as one health care professional on the Boundary reminded us, in the case of native Americans and other minorities in our society, the lack of self-esteem and self-confidence typical of adolescence can be aggravated by growing up as part of a "subculture" whose traditions are distorted and whose values are de-valued by the mainstream culture.

Cherokee Challenge seeks to give the young Cherokee a path that might lead them away from the depression, teen pregnancy, substance abuse and alcohol-related violence that local health care officials list among the major health problems on the Reservation.

To achieve this end, the program offers the young Cherokee physical challenges such as spelunking, kayaking and rock climbing trips in the mountains around Cherokee as well as training in the ropes course.

Such adventure outings are meant to expand what Challenge members conceive as their own physical and mental limits. These challenges are then complemented by a cultural education program. Children in the Challenge weave baskets and practice the beadwork and carving techniques of their forbears. They traipse the woods of the Smokies, learning herblore and plant identification. They dance the tribe's traditional dances. They experience firsthand the solemnity of the sweatlodge, the place where the sacred rites and traditions of the tribe are kept alive in ceremonies conducted in native Cherokee.

Natasha Cucumber, an 11-year-old member of the Longhair clan, still remembers months later the heat inside the lodge during the sweat ceremony: "They gave us a seasoning made of sage and cedar that was supposed to keep you from getting so hot. I put it in my mouth and held it there, but still I sweated a whole lot."

As Natasha spoke of the ceremony, her voice was not without a tinge of awe and reverence. Challenge staff members hope that by exposing the young Cherokee to vivid sensory experiences unique to the tribe—experiences like the sweatlodge ceremony—the children will realize they are part of a traditional culture that still has the potential to unite a community. And by fostering an understanding of what it means to be a Cherokee in the very young members of the tribe, the staff also hopes to give the young Cherokee the confidence that comes from pride in one's past.

Cherokee Challenge started out as a program targeted for high-risk children living on the Boundary—underachievers at school, abused children, unruly children. Partially because the program has turned out to be such a positive experience for most of the children who have been involved, and partially because parents are beginning to realize that *all* children are at some risk in Cherokee, the Challenge has grown and now finds members from all segments of the community.

Program director Tom Hill, himself a graduate of the program, explains the changing enrollment pattern in Cherokee Challenge: "In the beginning, the kids who came into the program were usually ones who were making trouble at school or at home. And it got so there was a stigma attached to being in Cherokee Challenge. Cherokee Challenge is still part of a substance abuse early intervention plan; we are still committed to finding kids who are at risk, but people are also starting to see that there are a lot of purely positive reasons for joining Cherokee Challenge. The kids learn a lot about their culture and themselves and most of the time they have a pretty good time doing it."

In the course of explaining the mission of Cherokee Challenge, Hill relates the story of a television reporter from the Midwest who once asked a young girl from the Qualla Boundary what it was like to live on an Indian reservation.

"It's not so different," replied the girl, "We've got McDonald's and Burger King just like everybody else."

Cherokee Challenge was founded in 1979 by members of the tribe because not all young Cherokee are as comfortable with their place in contemporary America as this girl. Despite the fact that the town of Cherokee—with its hotels, museums, outdoor pageants, crafts shops, and yes, fast food restaurants—does not on the surface appear very different from such other Appalachian tourist towns as Gatlinburg or Blowing Rock, the Reservation of the Eastern Band of the Cherokee is, in many ways, a world apart.

It's a paternalistic system. The schools are run by the Federal government. Its hospital is budgeted by Congress. The resolutions of the tribal council must be approved by the superintendent of the Bureau of Indian Affairs and U.S. Department of the Interior. The children on the reservation today have learned from their parents a strong distrust of the system, a distrust arising perhaps from memories of abuse at the old Indian schools for being "too Cherokee." These unsettling conditions have fostered doubts among many Cherokee as to whether they could survive off the reservation.

Pat Occumma is the director of the Women, Infant and Children program at the Indian Health Service Hospital in Cherokee. Her son has participated in

Cherokee Challenge, and she believes the Challenge has a positive effect on life on the Qualla Boundary: "Whether or not the children who take part in the Challenge stay on the reservation when they grow up, going through the program helps them to see their options and develop skills they need—skills like self-confidence and self-esteem—that will serve them well wherever they go as they grow older."

Like Natasha Cucumber, 10-year-old Teresa Catolster is a member of the Longhair clan. She is proud of the fact that she and her peers in the clan are the ones who plan the clan's activities. We talked to her right after a meeting of the Longhairs: "Yes. We just had a vote. We're going for a day hike this Sunday in the Smokies." Her voice had the poise and assurance of a five-star-general—or an Indian chief—discussing campaign strategy.

Recently, Cherokee Challenge has been hit with severe funding problems. The full-time staff of seven had been reduced in February, 1989, to a full-time staff of two, one staff member working part-time, and an increased reliance on volunteers to keep the program going.

But Tom Hill reports that the current difficulties are only temporary. State grant money has come through for a family enrichment program that will get whole families involved in Cherokee Challenge. A new after-school program for the kids of working parents and workshops for the Job Corps are also underway at Challenge headquarters.

The vital signs of the program are strong. Thus it seems that for the forseeable future Cherokee Challenge will continue to show the young Cherokee that the advantages of growing up on a Cherokee Indian reservation are certainly not limited to a couple of fast food restaurants. The Challenge will show a new generation of Cherokee that theirs is a homeland rife with the possibility for outdoor adventure, a community with a history of self-reliance older than America itself, and a cultural heritage richer than any milkshake they will ever get at Burger King.

Robert Gipe is a freelance writer living in Kingsport, Tenn. He has a master's degreee in American Studies from the University of Massachusetts, Amherst.
Additional research by Elizabeth K. Norfleet

I lost my health in the mines
Had operation for Tumor of Brain
Dec 17 1941
Local Union No 6051
Anything You Can Give Will
Be Greatly Appreciated.
Lorenzo Maxwell

In the liquor store on Saturday afternoon, Welch, W.Va., 1946. Photo by Russell Lee. From the National Archives.

Looking

Have you ever seen a face come
alive -
By feeling — without seeing?
Try it.
I recommend it, for those who
cannot feel
Without seeing.
A new dimension for those
Hungry for experience
Seeing is not all there is to living.

—Robert E. Cummings

Dr. Robert E. Cummings is a Counseling Psychologist at the Veterans Administration Medical Center, Johnson City, Tenn. Thirty years ago, Cummings lost his sight. His poetry and sculpture tell about his changes from "the land of the sighted to the land of the blind."

Reviews

Community Health Systems in the Rural American South:
Linking People and Policy
by Carole E. Hill

Westview Press
Boulder, Colo., 1988
$34.50 (hardcover)

Gary Burkett

I suffer from a chronic affliction characterized by an irrational reverence for books—both as physical objects and as agents of human discourse. I consider this an affliction because, in spite of all the contradictory evidence I have seen, I maintain the unrealistic expectation that all writers have something to say and that all books contain an almost sacred opportunity for human dialogue.

I remember an elementary school librarian who taught reverence for books as physical objects as she carefully demonstrated how to handle books with proper love and respect while we sat on the floor gathered around her feet. "This is how you open a book so as to ensure against breaking its spine." "This is how you turn the pages (grasping them at the upper right corner between thumb and forefinger and slowly smoothing them down) to make sure that you don't tear them." "And, of course, you must never never write in a book." I have felt a faint twinge of deeply embedded guilt whenever I have written in books ever since.

It was a college professor who taught reverence for the content of books as human discourse. I recall an impassioned lecture about how, since authors have gone to the trouble of setting their thoughts on paper, readers have the responsibility to listen carefully to what they have to say. The emphasis was on reading as dialogue—making sure that the author is heard fully and accurately prior to formulating a response. "We live in a society," the professor said, "where listening is an endangered art." I took that lecture to heart, mentally filed it along with the elementary school librarian's demonstration of book care, and continue to open each new book with hope and expectation. No amount of exposure to the "publish or perish" mentality of academia, where having something to say is not necessarily a prerequisite for publication, has managed to cure this serious mental deficiency.

Community Health Systems in the Rural American South by Carol E. Hill (professor of anthropology at Georgia State) has, however, brought me one step closer to curing my "reverence for books" affliction. This is one of the most disappointing books I have ever read; all the more so because the subject is one I care about. As a medical sociologist one of my main areas of interest is the "subclinical" realm of health and illness—health and illness as manifested in the everyday world rather than only as defined and treated by the medical care system. The influences of society and culture on people's perceptions and behaviors regarding illness are profound. Whether, for example, a certain kind of behavior is "diagnosed" as an "epileptic seizure" or "revered" as "possession by the holy spirit" is largely a function of the cultural context. I was intrigued by the promise of Professor Hill's book, to examine how "health care systems are structured and transformed within the larger context of the political, economic, cultural, and social systems in which they exist." This book was already on my "books-I-intend-to-read" list before I was invited to review it.

My interest in this work was increased because of its focus on health in the rural American South—a subject which has received relatively little systematic attention, and because it claims to be based on an intensive investigation of a single small rural community—identified by the pseudonym "Coberly" in this monograph. Hill's expressed intention to "analyze the health problems of the people of Coberly, their illness behavior, their health-seeking behavior, and their beliefs and attitudes about health" struck me as a promising concept. Furthermore, her desire to contrast the health-related assumptions of this community with those of health planners and policy-makers also resonated with my own interests and gave me particularly high expectations for this book.

These expectations lasted for only a few pages. The first challenge arose from an extreme lack of clarity and precision in her writing which often necessitated rereading sentences in order to figure out what she meant to say. Try, for example, "While all the people of Coberly feel there is a uniformity in causes of illness (a statement contradicted by her own data) and everyone has an equal chance of becoming ill, the majority believe that there are specific kinds of people who become ill more than others." Other challenges to my attempt to enter into meaningful dialogue with the author kept appearing, for example: the reliance on 1970 census statistics for a book published in 1988; the combination of copious and gratuitous citations (often to her own work) in some sections with a total absence of citations in other instances where they were really required; and a remarkable capacity to toss off clearly erroneous overgeneralizations. For an example of the latter, consider Hill's statement that, "the health status of rural people is worse than that of any other population." Worse than American migrant workers? Worse than the urban homeless? Worse than the population of Bangladesh?

Most disappointing to me was the superficial and cursory description of the cultural models of health and illness employed by the people of Coberly. While we learn that Coberly has an average temperature of 62.9 degrees F (45.8 in winter and 79.1 in summer), the descriptions of Coberly's people—with the exception of a few brief case studies—tend to be shallow and stereotypical. ("In contrast to Whites, about 20% of the Blacks of Coberly report that they usually do not do what the doctor tells them to.") Furthermore, interpretation of such statements is seriously hampered by Hill's failure to describe her methodology in any detail. In this 220 page monograph, only two paragraphs are devoted to describing how Coberlians' opinions, attitudes and beliefs were investigated. Most importantly, at no point does Hill seem to consider the possibility that her interaction with the people she interviewed was, itself, subject to cultural influences. While she recognizes that

patients may withhold or distort information when they consult physicians, she fails to ponder the impact that her own role as "outsider" social scientist may have had on the information provided to her by the residents of Coberly.

There are some good things in this book. There is a nice historical summary of federal programs aimed at improving rural health. Varied governmental statistics related to urban-rural health differences are gathered here in one place. Many of the ideas espoused here are laudatory; one only wishes they had been developed with more care. The whole book, in fact, seems to suffer from lack of care. I felt very little guilt as I scribbled all over its pages.

Gary Burkett, Ph.D. , a sociologist, is professor and director of research in the Department of Family Medicine at the Quillen-Dishner College of Medicine at East Tennessee State University.

Appalachian Mental Health

edited by Susan Emley Keefe

University Press of Kentucky, Lexington, Ky., 1988
$25.00 (hardcover)

Steven L. Giles

Susan Keefe, an anthropologist at Appalachian State University, has prepared as a text the scholarly work growing out of a symposium on mental health in Appalachia held in Madison, Wisconsin, in 1981 and a subsequent workshop organized at ASU in 1982.

The work is a compilation of writings by 17 authors on a wide but uneven range of subjects. Although an ambitious undertaking, with the jacket claiming the book to be "the first to explore broadly many important theoretical and applied issues concerning the mental health of Appalachians," I found the work generally weak, especially from the practitioners' point of view.

It is absolutely necessary when dealing with a subject as broad as mental health and as diverse as Appalachia to struggle with basic definitions. Keefe not only fails to define mental health or illness, she ignores sorting out the wide range of mental health treatment techniques. The work fails to reference the important epidemiological studies relevant to this region. I would suggest that any text on this subject that ignores the contributions to the field of mental health that came about as a result of the tragedy at Buffalo Creek in West Virginia in 1972 is incomplete. Even a section on Further Readings would have helped—or an appendix demonstrating at least general awareness of the broad range of mental health services scattered across these mountains.

I suspect I am shouting across that well-known gap which separates the practitioner and the scholar. My impression was that the majority of the book's authors were academics with little experience or training in mental health. By this I mean that most would not be able to diagnose accurately bipolar illness or post traumatic stress disorder, for instance, let alone develop a treatment plan or conduct the care of the patient with the condition.

A strong article by Rhoda Halperin and Marcia Slomowitz on hospitalized Appalachian adolescents is an exception. The rich case material presented by Cynthia Cole, the themes presented by Thomas Plaut growing from organized interviews with agency staff members, and the sensitive insights on the self-perceptions of Appalachian women by Judith Fiene are also strong chapters of particular value to practitioners.

Mental health planners and administrators are other professionals certain to find *Appalachian Mental Health* less than satisfying. The chapters by Cathy Efird and Keefe on planning and utilization are simplistic, poorly documented and include recommendations that are so general as to be, in my opinion, dangerous. I find the book's endorsement of therapies that are more directive, advice oriented and interventionistic to be especially shortsighted.

David Peters and Gary Peterson actually recommend that therapists "assume a supervisory role within the therapeutic relationship." It seems to me that this reasoning contradicts the book's frequently expressed concern that "outsiders" are terribly compromised as helpers. Nevertheless, several authors call for prescriptive guidance. From my perspective, it is simply best that neither "insiders" nor "outsiders" be encouraged to tell Appalachians (or anyone else) how to live their lives. Advice is not the essence of mental health care.

Melanie Sovine's disdain for administrators is insulting to this administrator. She speaks well for the need for a professionally relevant literature on Appalachian Studies, but she accuses administrators in general of being insensitive to the issue of quality care. She summarizes an interaction with an executive director with this statement: "I, therefore, can say that I have known and worked with health care professionals who clearly embody the worst professional images in Appalachia."

This sentiment has no place in a scholarly work. And such hyperbole as this: "For all patients, polymedication was a severe problem," tarnishes an otherwise thoughtful commentary. Sovine's "transition" from anthropologist to primary therapist during her community mental health assignment would be frightening to any trained mental health practitioner with a basic understanding of psychopathology and psychotherapy.

While Keefe is to be applauded for bringing together an interesting array of authors with strong (though at times contradictory) opinions, I feel the work could have benefitted from a stronger editorial hand. The majority of the writing is poorly referenced, making it difficult to sort out opinion and commentary from data-based information. At times I had the feeling that in the "new" Appalachian culture neighborliness, egalitarianism and the wonders of the extended family are just a late 1980s version of the old fatalism, independence and clannish behavior. I expect more from modern ethnography.

Cole, Richard Humphrey and Keefe

Appalachian Mental Health

all emphasize the fear and suspicion that Appalachians are supposed to have of institutions, outsiders and helpers. These authors show poorly-veiled hostility towards those "outsiders" who care for Appalachians in hospitals, primary care settings, community mental health systems and a myriad of other settings. As an "outsider" myself I am growing tired of this kind of innuendo. I supervise a staff of a dozen professional psychologists who work only with rank and file Appalachians. Only two were reared in Appalachia, but all have excellent training and credentials. They are dedicated professionals. Their service to Appalachia, along with the service of many like them, does not deserve the portrayal it receives in the book. Perhaps when our regional academic leaders can resolve their own fear and suspicion about "outsiders" or at best develop some empirically sound data on the subject, they can begin to play a positive role in the improvement of mental health care in the region.

Appalachian Mental Health is not what it pretends to be. It would do well to look at the assumptions it so proudly displays as facts. As a practitioner and administrator I expect better scholarship from our region's thinkers.

Steven Giles, Ph.D., a clinical psychologist, is the chief of psychology services as the Veterans Administration Medical Center Johnson City, Tenn. He is also clinical assistant professor in the department of Family Medicine and Department of Psychiatry and Behavioral Sciences at the Quillen-Dishner College of Medicine at East Tennessee State University.

Because the Buffalo Creek disaster led to important, seminal research and literature in mental health, we asked Pamela Zahorik for a new review of one important book.

Everything in its Path

Destruction of Community in the Buffalo Creek Flood by Kai T. Erikson

Simon and Schuster
New York, N.Y., 1976
$8.95 (paperback)

Pamela Zahorik

On February 26, 1972, after a seasonal rain, Buffalo Creek in West Virginia was flooded and destroyed by over a million tons of water, mine dust, shale, clay and metal and timber refuse. This disaster devastated the combined communities of 5,000 people by leaving over 125 dead and 4,000 homeless.

Everything in its Path arose from observations and interviews with the survivors of this flood. The information was originally gathered as court evidence for a legal suit that was filed against the coal company responsible for the mining refuse that descended upon the valley. The result of this endeavor, however, is more than a simple account of facts needed for legal proceedings. Erikson provides us with a portrait of the Appalachian region and people that integrates their specific culture, history and economic situation. Even if one disagrees with his analysis, the importance he places on understanding the ethos of the people, which was uniquely suited to the environment and economics of the region, should be applauded.

The thesis of this work is stated in the subtitle, "Destruction of Community in the Buffalo Creek Flood." Erikson, a sociologist, places emphasis on community, and it was this loss of place and familiar faces that proved the enduring

People Helping People — More lessons

In 1985 devastating floods covered more than half of West Virginia: 29 out of 55 counties were declared disaster areas. Forty-seven people lost their lives, there was $500 million in damages, 8,000 homes were damaged or destroyed.

Had anything been learned from Buffalo Creek about easing the pain of loss and about maintaining community in West Virginia in the face of disaster?

Mariwyn McClain, the editor of the *Parsons Advocate* in Tucker County, felt the loss of community acutely. She says that more than 90 businesses were demolished in Parsons, and more than a dozen have never recovered. A year after the flood, only 16 families had moved back to her street, where before there had been 55.

While the government reaction was slow and confusing—which contributed to the problems—the efforts of nearby individuals and of religious and private relief agencies provided the first, best response to the disaster. "It was people helping people as opposed to government helping people," says Phoebe Heishman, editor of the *Moorefield Examiner* In Hardy County.

"Immediately after the flood, there were nightly meetings in Moorefield," reports Miriam Leatherman, a Hardy County Extension Agent. Organizations, churches and individuals got together to see who needed help and to coordinate efforts. An Interfaith Task Force formed, and churches, community groups and agencies began working together better than they ever had before. "The flood washed away a lot of prejudices and worked for the common good of the entire community," says Leatherman.

Some long-term good came out of the flood for Moorefield residents. The Interfaith Task Force kept meeting, becoming the Family Issue Task Force. They've launched programs including ones on drug abuse and child abuse. "It's a real positive aftermath of what had

tragedy for the survivors along Buffalo Creek. It was not only the devastation by the flood, but the capricious nature of the relief efforts that hindered the recovery of communities in the flood area. Emergency relief efforts placed people in rent-free mobile homes in designated areas. What this altruistic deed accomplished was "to take a community of people who were already scattered all over the hollow, already torn out of familiar neighborhoods, and make that condition virtually permanent."

As much as the people of the hollow mourned the loss of a house and belongings, the greater sorrow was the loss of supportive networks—familiar friends and neighbors. Erikson states that "the camps served to stabilize one of the worse forms of disorganization...by catching people in a moment of extreme dislocation and freezing them there in a kind of holding pattern." Individuals experienced severe psychological trauma, and without the context of a secure community the healing process was stymied.

The importance of the perspective of community members is well illustrated in the opening pages of the book. Erikson arrives to begin his work and innocently comments to a resident that "a storm might come up and cool the air." From the disdainful reaction with which his comment is greeted, Erikson concludes, "One does not mention storms casually on Buffalo Creek, and one certainly does not appear to welcome them as relief from uncomfortable weather." This observation intones the need to gather the perspective of the people—an insider's view to grasp the effect of an event on the community.

Most of the American population is very mobile. Perhaps the majority of us do not appreciate the security and sense of belonging that a familiar community provides. When earthquakes, floods and hurricanes devastate communities worldwide, we are generous providers of emergency aid. The lesson of this book is that the very measures taken in an emergency situation may prove equally detrimental to the long-term recovery of a community. The long-term health of the people of a community must also be attended. This means a recognition of the need of mental health care and assessment of the needs and concerns of the people, by the people, in the aftermath.

Although *Everything in its Path* was published over a decade ago, its lessons should be heeded today. As decisions are made to relocate people to further urban renewal, grant lands to American Indians thus moving them hundreds of miles from their birthplaces, or address the issue of immigrants arriving from warring countries, we must remember that a deeper trauma may be in the making—that loss of a sense of belonging which can come from involuntary exile.

Two films from Appalshop focus on the Buffalo Creek disaster of 1972: *Buffalo Creek Food: an Act of Man*, filmed in 1975, and *Buffalo Creek Revisited*, filmed in 1984. Both are directed by Mimi Pickering. For more information contact Appalshop at 306 Madison St., Whitesburg, Ky. 41858. Phone 606-6330-0108.

in community, 1985

happened," says Heishman.

The earlier Buffalo Creek disaster might not have prepared the federal government or the people of West Virginia to cope with another devastating flood, but at least one individual from Buffalo Creek knew how to ease the loss. Leatherman says that fellow extension agents were brought in from around the state to help including one man from the Buffalo Creek area. "He brought home-made Christmas ornaments. We were still thinking about food and shelter, but when the time came, he knew we'd want them." And it was true. It was just a few days before Christmas when the cleanup and repairs on the Leatherman's flood-ravaged home were far enough along that they could move back in. They put up a Christmas tree, and though all of the family ornaments had been lost in the flood, the tree had personal decorations—because of a gift from someone who remembered Buffalo Creek.

—Pat Arnow

Residents being rescued by volunteer firemen and emergency squad members in Philippi, West Virginia, November, 1985. Photo by Lars O. Byrne, *The Democrat*.

Reviews

Emerging Patterns in the Southern Highlands: A Reference Atlas Volume III Health Care

by Paul E. Lovingood and Robert E. Reiman (eds.)

Appalachian Consortium Press
Boone, North Carolina, 1987
$6.95 paperback

Richard Couto

The Appalachian Consortium has produced an inexpensive, well-edited volume that deals with health care in the region. It is part of a series that will cover a variety of aspects of life in Southern Appalachia. The material is clear and presented as a literal atlas with maps for every measure. The Appalachian Regional Commission cooperated with the study. This is precisely the type of information and inexpensive format that scholars, planners, policy-makers, students, community leaders and others need.

Unfortunately, this publication falls short of its purpose and does not serve adequately the need that exists. First, the data are dated. Some information goes back to 1977, and the most current data on health measures are1983. Second, little of the data is comparative. The atlas offers a series of measures for a single year and very few measures of two or more years so that we can discern the direction and rates of changes. Rather than an atlas by which we can chart a course of where we have been and where we might be going, this publication is more like a series of mileage markers that provide a look at a series of fixed points.

The interpretive essays also fall short of their purpose. There is a stress on isolation and cultural factors in dealing with health issues and the provision of health care. While these are undoubtedly important, Appalachian health conditions are a consequence of the American health care system. Tom Connelly's essay touches on this point in his discussion of uncompensated care and lack of private health insurance for some working people. There is no discussion of the United Mine Workers effort to deal with these issues 40 years ago even though this reform effort left a remnant of hospitals and one Health Maintenance Organization (which this atlas reports).

It is the shortcomings of this volume that offer its most important lessons. First, we do not have very good data to analyze social conditions in the region. Editors of studies like this are hampered by a lack of the appropriate data and end up compiling and reporting data that are available rather than explanatory. Second, the region tends to be defined by the interests and needs of the researcher. The 156 counties of this study were selected somewhat arbitrarily by the "sphere of influence" of the members of the consortium that published the atlas.

As regional researchers we need to do better. We need to adopt uniform definitions of the region. The Appalachian Regional Commission's definition of the region and sub-regions would be appropriate since much of analysis is already done in its terms. This would permit readers to compare studies of the region done at different times and by different authors much better than we can now. Researchers also need access to current and relevant national and state data for subsets of Appalachian counties. The Appalachian Regional Commission is an organization that can provide data. Its capacity to assist in research efforts is evident in this volume. ARC has made considerable contributions in improving health care in the region, as can be noted in the data of this atlas.

The shortcomings of ARC are also evident in this volume. The foreword by federal co-chairwoman Winnifred Pizzano is an example of the Reagan-era approach to public policy We are invited to scale new "peaks of opportunity and achievement," to address substantial problems by challenging old assumptions and assessing alternatives, most of which have to do with dwindling federal support and commitments to social programs, and to disregard the contribution that the Reagan administration's policies have made the region's new and exacerbated problems. We need more from ARC if we are to have better regional analysis. The Reagan administration attempted to end ARC and ignored it when it couldn't end it. We need federal commitment to serve regional needs through ARC and better data collection, reporting and analysis are part of that need.

ARC is needed if we are to have first-rate analysis of the Appalachian region but we need other resources. The various centers and consortia of the region are important in the production of information on the region. The development of their research capacities has been substantial and an important change within the region. But we may get further in acquiring and reporting the data we need about the region if these research centers cooperate to identify the needs for data and work at the federal and state level to acquire and then develop means to share it. At present, some centers are developing their own data banks and others, like the present study, acquire what they can get from a depleted ARC and other sources and report it.

Our improved analysis needs to extended beyond data. We need to develop a more critical perspective on the region's problems. State and national policies, macroeconomic trends and the organization and delivery of human services such as health care contribute to Appalachian needs. These regional needs are just one instance of inequality in American society, and we need to present them as such for two reasons. First, to continue an analysis of the problems of the region as isolation and culture undermines their public nature. Secondly, there is no public instrument to deal with suprastate regional problems except the federal government, and there is little reason for the federal government to deal with Appalachian problems except as part of a national need.

The editors of this volume are to be commended for their effort and the Appalachian Consortium Press commended for its commitment to providing information in an inexpensive format. This atlas itself, however, measures the distance we have yet to go in the analysis

of social problems and policies in Appalachia.

Richard A. Couto is professor of public administration of the Institute of Government at Tennessee State University and wrote, ***Appalachia—An American Tomorrow: A Report to the Commission on Religion in Appalachia on Trends and Issues in the Appalachian Region*** *(1984).*

Emerging Patterns in the Southern Highlands: A Reference Atlas Volume I, Introduction (with general information) and Volume II, Agriculture, are also available from Appalachian Consortium Press for $6.95 each. Volume IV, County Business Patterns, is forthcoming.

Gunn's Domestic Medicine

by John C. Gunn

Introduction by Charles E. Rosenberg

Tennesseana Editions
The University of Tennessee Press
Knoxville, Tenn., 1986.
Reprint of 1830 edition
$24.95 (text edition)
$12.95 (paperback)

Richard Blaustein

Dr. John C. Gunn's *Domestic Medicine, or Poor Man's Friend in the Hours of Affliction, Pain and Sickness* was one of the most popular medical self-help books of the frontier era.

Primarily intended for settlers far removed from hospitals and clinics, Gunn's dictionary was a common source of authoritative medical knowledge in the homes of rural Americans from 1830, when the first edition was published in Knoxville, Tenn., until 1920 when the last edition was issued by a Philadelphia publisher.

Reading Gunn today, one realizes how difficult it is to make rigid distinctions between academic, folk and popular medicine. Scientific medicine as we now understand it simply did not exist in Gunn's day.

Like many of his contemporaries, Gunn's approach to healing was eclectic and symptomatic. The theory of humors and herbalism was as relevant to his practice as the prescription of powerful drugs such as mercury, opium and ipecac, all of which he dispensed unreservedly with no apparent sense of their noxious side effects.

He was not a strict partisan of the botanical school of medicine which rejected bleeding, purging, and dosing with harsh drugs in favor of supposedly more natural vegetable remedies. But Gunn acknowledged the efficacy of medicinal herbs, many of which are still employed by Southern Appalachian folk practitioners.

As Charles E. Rosenberg notes in his lucid introduction, Gunn was a populist who assumed that his lay readers possessed empirically valid medical knowledge not necessarily inferior to that of professionally trained practitioners: "In the vast majority of instances the trained physician could offer little in the way of therapeutics different from the drugs, bleeding, minor surgery, and hygienic advice available to any self-confident adult."

Indeed, as Rosenberg observes, before the era of Pasteur and Koch and the advent of modern biomedicine, the conceptual and methodological gap between folk and professional healers was not nearly as wide as it has become today. Much of what we currently think of as folk medicine was the conventional medical wisdom of an earlier period. Gunn and other major popular 19th century medical writers acknowledged the efficacy of non-magical folk remedies, especially herbalism. In turn their dictionaries helped to perpetuate such therapeutic practices as home remedies long after they had been abandoned by most professional clinicians.

Regarding the causes of disease, Gunn, like many contemporary folk healers, believed that interference with the body's natural equilibrium resulted in sickness, and that mental and emotional distress had destructive physiological consequences. Gunn even gave credence to the still common folk belief that unborn children could be physically "marked" by emotional upsets experienced by their mothers. Most modern physicians would, however, be willing to accept the idea that health is a state of relative equilbrium or homeostasis, which can be affected by psychological as well as organic stress factors.

One of the most valuable lessons to be derived from this attractive facsimile edition of Dr. Gunn's dictionary is an enhanced appreciation of America's diverse medical cultures, particularly here in the Southern Appalachians, where it is possible to observe oldtime remedies and new age alternatives co-existing with various schools of professional academic medicine.

Contrary to the expectations of proponents of scientific biomedicine, advances in medical knowledge have not necessarily resulted in the disappearance of other therapeutic approaches but have only increased the health care options available to the patient. As David Hufford notes in *American Healing Systems: An Introduction and Exploration* (1984), only one out of 10 health crises is ever brought to the attention of professional practitioners. The rest are treated at home, as in Gunn's day, or else brought to the attention of various types of healers, ranging from licensed to clandestine.

A truly comprehensive, realistic understanding of health care in Appalachia (and America as a whole) must necessarily include the full gamut of therapeutic approaches, not just professional medicine. Individuals as well as societies can be medically pluralistic; we should not be surprised to find people seeking relief wherever they think it might be obtained, whether at the hands of professionals or other types of health care providers.

Rosenberg's introduction enhances the value of what is otherwise an essential addition to the library of the medical historian, folklorist or student of Appalachian cultural history. Stimulating reading.

Richard Blaustein is Director of the Center for Appalachian Studies and Services and a past-president of the History of Medicine Society of Appalachia.

Lunatic Asylum

Richard Blaustein suggested this song for the ***Now and Then*** *health issue. The song was collected in 1975 by cultural anthropologist Anthony Cavender. The late Mary Elizabeth (Lizzie) Broyles, a midwife and traditional singer, sang this unusual original ballad. She learned it from one of her aunts who had suffered a nervous breakdown and was sent to a lunatic asylum. Mrs. Broyles lived in Limestone, Tenn. She explained the history of the song to Cavender before singing it for him:*

Lizzie Broyles: ...crazy; she just stayed in the graveyard and she went crazy.

Anthony Cavender: Now wait a minute, let's go back. Two women wrote this song...

L.B. Composed it, yes.

A.C. And they were in an asylum?

L.B. Yessir, they were as crazy as bedbugs, but they made this...

A.C. And one of them married who?

L.B. One of them married my mother's brother; she was my aunt. And she just stayed at the graveyard—they never had no children—and she just stayed at the graveyard and worried over him until she went crazy.

A.C. Oh, he died and that's what drove her crazy.

L.B. He died, and that's why she went crazy.

A.C. She grieved herself to death. You don't remember any of the song?

L.B. Yeah, I can remember some of it.

A.C. You knew the person who wrote that song, then?

L.B. Oh Lord, yes! She was my aunt!

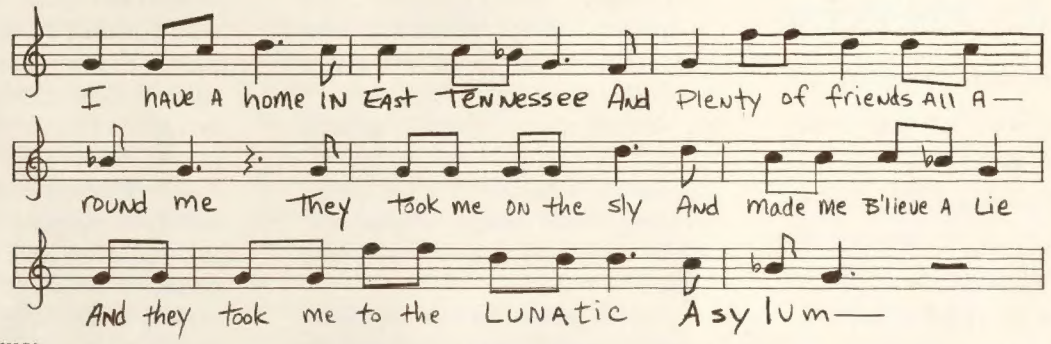
A.C. And she wrote that song herself...

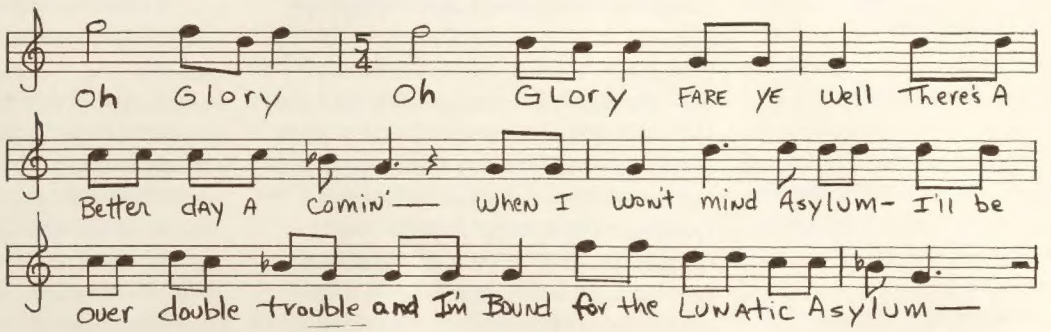
L.B. Her, and another lady in the asylum.

A.C. They both got together and wrote it?

L.B. They got together and made it. I'll have to sing it as it comes to me. Let's see...

Unaccompanied ballad


I have a home in East Tennessee And Plenty of friends all a—
round me They took me on the sly And made me B'lieve a Lie
And they took me to the LUNATIC Asylum—

Chorus:

Oh Glory Oh Glory FARE YE well There's A
Better day A comin'— When I won't mind Asylum- I'll be
over double trouble and I'm Bound for the LUNATIC Asylum—

2)I guess I'd better tell
about the patients that was there,
the patients they were all thick around me
They could come down so thick
thet they'd give you many of a lick
When they had me in the Lunatic Asylum...

Chorus:
It's oh glory, oh glory!
Fare ye well, there's a better day a-comin'
When I won't mind asylum
I'll be over double trouble
and I'm bound for the happy land of Canaan

3) Yes, I guess I'd better tell
about the jackets that was there
The jackets they were thick around me
They would lace 'em on so tight
that it made you want to fight
when they had me in the lunatic asylum

Chorus

This article is excerpted from "The Lunatic Asylum': Folksong as Healing Process?" by Anthony Cavender and Richard Blaustein in the ***Tennessee Folklore Society Bulletin,*** *1979, 45(1):1-11. Used by permission. "The Lunatic Asylum" can be heard on the album, "Tennessee: The Folk Heritage. Vol. 2, The Mountains," TFS-103 issued by the Tennessee Folklore Society.*

—Ed Snodderly

Dickenson County, Va., 1973. Photo by Ken Murray.

Downtown Johnson City, Tenn., 1988. Photo by Michael Smith.

NOW AND THEN

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